Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Deal 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 20 Huff Edgar George Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** Dec 26, ^{ear}1931 218-24-8188 1 X M 2 D F 80 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Cumberland Allegany MD 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21502 11114 Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married þ 1 🗆 Yes 2 🗡 No Baltimore, Maryland 21215-0036 If Yes, Give white "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) ABL production scheduler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Cecelia Hammersmith 2 George Walter Huff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 11114 Creek Road Cumberland and lis m 19a. Informant's Name/Relationship (Type, Print) MD 21502 Joyce Huff wife of Health a 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Important: If it any injury or o 1 Burial 2 Kremation 3 Removal from State 6/25/2012 Scarpelli Funeral Home MD Cresaptown nation 5 Other (Specify) 22. Name and Carpelli Fulleral Home, PA gnatur Funeral Servio License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cance weeks Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) n any, reading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day in the past 12 months? Pregnant at time of death should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral injury Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD 21502 SEMAAN M.D. 12501 Willow brook Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | - For | State of Ma | aryland / I | Departmer | t of Healt | th and N | Иental Hy | giene | | |
|---|------------------|---|--|---|-----------------------------|---------------------------|------------------------------|----------------------------------|----------------------------|--------------------------------------|--|
| | | State Registrar | | | Certificate | e of Deat | h | | Reg. No. 2 | 0.1.2 | 22002 |
| Physicia | n/ | 1. Decedent's Name (First, Middle, I | .ast) | / | | | _ | 2. Date of De | ath Day | Year | 3. Time of Death |
| Medic | ai | Michael | TW(M) | UK | 1 | | | JUNE | 22 | 2012 | 12:46 PM |
| Examin | er | 4a. Facility Name (if not institution, g | HOSPITA | VL CEN | | Town, or Locati | ion of Death | 1 AM | 4c. County | of Death | |
| Funeral | | 5. Social Security Number 6 | . Sex 7. Age | (In yrs. last birt | hday) If Under | | nder 24 Hrs. | 8. Date of Bir | th | | lace (State or Foreign |
| Director | | 220-32-1523 | 1 X M 2 □ F | 96 | Yrs. Months | Days Hou | ırs Min. | (Month, Da | | Count POLAN | ** |
| and show at | o. | Usual Residence of Decedent 10a. State 10b. County | | 86 10c. City, Town | n or Location | | | 02/10/1 | 1920 | | Dd. Inside City Limits |
| Maryla 28a-f s | Funeral Director | MD KENT | | CHESTER | RTOWN | | | | | | 1X Yes 2 □ No |
| h the Saor | al D | 10e. Street and Number | | | 10f. Zip | Code | | | 10g, Citizen of \ | What Coun | try? |
| ns 2% | ner | 121 MALONE AVENU | | | 216 | | 0-1-1-0-10- | :f-: \/ N - | S | | |
| 6 er dea or ite | by Fu | 11. Marital Status1 ☐ Never Married 2 ☐ Marrie | 12. Was Decedent E Armed Forces? d ☐ Yes 2 X ! | ver in U.S. | If Yes, spec | ify Cuban, Mex | congin? (Sp kican, Puerto | ecify Yes or No- Rican, etc.) | | e - America k, White, e | |
| 21215-0036 within 72 hours after death with the Maryland giene. ler than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at | ted t | 3 X Widowed 4 Divorced | If Yes, Give Year or Dates. | | 1 ☐ Yes | 2 X No <i>Sp</i> e | cify: | | Specify: | WHIT | E |
| 15-(| Completed | 15. Decedent' (Specify only highest | | 16a. Decedent's Usual Occupation (Give kind of work done during most of life, DO NOT use retired) | | | most of work | ing | 16b. Kind of B | usiness/Ind | lustry |
| vithin iene. | | Elementary/Secondary (0-12) 12 | College (1-4 or 5- | | RM MANAG | , | | | AGRICU | LTURE | |
| > 0 U | Be | 17. Father's Name (First, Middle, Las | st) | | | | other's Nam | ne (First, Middle, | Maiden Surname | | |
| farylan should be fill and Mental is marked o | 유 | MICHAEL IWANIUK | | | | DO | NJE | | | | |
| > <1 = 5 = 5 | | 19a. Informant's Name/Relationship | - | | o. Mailing Address | | | | | | · 1 |
| | | HANNELORE SUNDY 20a. Method of Disposition | | 20b. Place o | CAMINIR f Disposition (Nan | ne of | | Date | 20c. Location - | | |
| Page 1 | | 1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | | ry, crematory or o | | 06/25 | 5/2012 | STEVENS | VTI.T.E | , MARYLAND |
| Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe | | 21. Signature of Funeral Service Lic | ensed | . 7 | | | | The state of the second | | | OME, P.A. |
| □ □□ = □ □ | | Deck J. | selfenbe | en | 130 SP | EER ROA | D CHES | STERTOWN | I, MARYL | AND 2 | 1620 |
| Die i i / | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final | y one cause on each line. | | | . 100 | | or respiratory ar | | | Approximate Interval Between Onset and Death |
| Physician/ Medical | 9 | disease or condition resulting in death) | a | STIT. AC | | 0,20 5 | 1373 | SENTSE | | \rightarrow | |
| Examiner | | Sequentially list conditions, | h ——— | | | | | | | | |
| sit d | Examiner | if any, leading to immediate cause. Enter Underlying | Due to (or as a | consequence | isequence org. | | | | | | |
| executed an and rial-transi | Exar | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequence | of): | | | | | _ | |
| ords, P.O. Box 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | dical | | d | | | | | | | | |
| 6876 certificat nding ph use as th | Mec | IF FEMALE: | | | | | | | | | |
| Box 6 death cer the attendined for use | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at | 2 🗌 Fetal deatl | h 3 🗌 Ectopic p | | | | | te of delive | ry Day Year |
| the degraphed by the a | Physician/Me | 1 Yes 2 No 9 Unknown | 9 Unknown | time or death | J 🗆 Other (s) | | | | | | |
| that the | by P | Part II. Other significant conditions | s contributing to death bu | ut not resulting | in the underlying | ause given in F | Part I. | 23e. Did to | obacco use conti | ribute to the | e cause of death? |
| 'dS, | | | | | | | | 114 | Yes 2 □ No | 3 🗌 Prob | ably 4 Unknown |
| law re has bo | Completed | | | | | | | 24a. Was auto | osy | Were autop prior to con death? | sy findings available npletion of cause of |
| n; The filicate or, pag | | 25. Was case referred to medical | 1 | | | 06 Plans of l | D++4h /Oh | 1 U Yes | | 1 Yes | 2 No |
| Vita ysicia ysicia is cert direct | To B | examiner? | Hospital: | ent 2 🗆 ER/Ou | utpatient 3 D | Other: | | | dence 6 🗆 Othe | er (Snecify) | |
| ng Ph | | 27. Manner of Death Natural 5 ☐ Pending | 28a. Date of injur (Month, Day, | y 28b. 7 | | 3c. Injury at work? | | | now injury occurre | 1 - / - / / | |
| SION ttendi death stor: A y the f | Certificate: | 2 Accident Investiga 3 Suicide 6 Could no | t he | At barra fo | M M | 1 Yes 2 | 2 🗌 No | 0011 11 11 | | | 5 |
| DIVISION OF VITAI RECORGS, tal or Attending Physician: The law requires safter death. In Director. After this certificate has been signed in by the funeral director, page 2 should the | | 4 ☐ Homicide determine | ed 28e. Place of Injur | | iriii, street, iactory | , office | | City or Tou | Street and Numbern, State) | er or Hurai | Houte Number, |
| Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for | Medical | 29a. Certifier 1 Certifying P | hysician: To the best of raminer: On the basis of ex | | | | | | | | |
| thin 24the F | | only one) /3 Certifying N | urse Practitioner: To the | best of my know | wledge, death occ | rred at the time | e, date and pl | ace, and due to t | the cause(s) and n | nanner as si | tated. |
| P ₹ P 8 | | 29b. Signature and title of certifier | | mv | 290 | Danie numb | 711 | 30 | 29d. Date signed | i (Month, D | ay, Year) |
| | | 30. Name and address of person wh | io completed cause of de | eath (Item_23a) (| Type, Print) | 700 | 11' | | 0070 0 | -1 | , |
| ms | | FERT JACOB | J 100 | BRO | L Lu | ALS € €- | 1 | afres7 | ESTOUN | M | se(s) and manner stated. lated. lated |
| Stat Registra | | 31. Date filed (Month, Dey, Year) | 32. Registra | r's Signature | 1. park | 3 | | | | | |
| | | RIN & | e auto | | | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Re Medical 4a. Facility Name (if not institution, give street and number) Examiner b. City, Town, or Location of Death 4c. County of Death Baywoods Annapolis Anne Arundel Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 579-20-2681 97 **Director** 1**E**FM 2 □ F 10/4/1914 DC Usual Residence of Decede 28a-f shov 10a, State "natural", or items 23a or 28a-f sho irector 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 Yes XX No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3307 Arbor at Baywoods 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, was becedent Ever in U.S.
Armed Forces?
1 ★ Yes 2 □ No 1942—
If Yes, Give
Year or Dates. 1946 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo White Specify. XX Widowed 4 Divorced Specify: Completed 1946 and Mental Hygiene.
Is marked other than "natur Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Lincoln Irey Marguerite Wagner 1 and 2 should be of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Irey Daughter 192 Berrywood Dr. Severn Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If its
any injury or of 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 6/20/12 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician END ONGESTIVE HEART FAILURE onset and Death THAE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Year signed by the at d be detached for Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: autopsy perform Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To me pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certified se of death (Item 23a) (Type, Print) OK-PORTH MO 31. Date filed (Month, Day, Year) 32. Projistrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

JUN 2220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 Norman E. Jones Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIOMICO REGIONAL MEDICAL TENINSULA Centu 344156414 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours 218-50-1659 Director 65 1 X M 2 □ F 05/06/1947 Maryland Usual Residence of Deceder ir then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Eden Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21822 4151 Stockyard Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. à 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 hours aftar 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Electric ge 1 and 2 should be filad wit nt of Haaith and Mental Hygle t: If itam 27 is marked othar or other traumetic avent, II Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert Paul Jones Rosa Belle Hurtt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty E. Jones/Spouse 4151 Stockyard Rd., Eden, MD 21822 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Departmant of H
importent: If Ita
eny injury or ott Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Othery(Specify) 6/22/2012 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P.A. 821 West Rd., Salisbury, MD 21801 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) mth Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate ba executed attending physician and I for use as the burlal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No 2 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha within 2 only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) AUD41211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando 100 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

JUN 25 2012

| Physician | enry Thomas J | ludk | 1- For State | tate of Maryla | • | artment of | | nd Men | tal Hyg | | eg. No. 2 | 0 | 2 220 | |
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| To Silve Town or Location | Director | | | 1 X M 2 F | 64 | 4 Yrs | | ys Hours | Min. | May 2 | 24,1948 | Cou | ntry)Indiana | L |
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| Physician / Medical stammer 23a. Part I. Enter the bases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed list one of the support | ore, N s 1 and 3 of Health fritem | | Zoa. Method of Disposition | | 200. | i lacc of Diopos | ition (Name of c | | | | | | | |
| Physician / Medical stammer 23a. Part I. Enter the bases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed list one of the support | ltimo it. Page artment ortant: | ı | 4 Donation 5 Other S | pecify: | Ft. | 100.1 | | | | | | | | |
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| CO C of Separation of the Company of | /Medical | | failure. List only ne cause | on each line. | | n, Do not enter ti | ne mode of dyin | g, such as ca | ardiac or re | espiratory arre | est, shock, or hea | п | Between Onset ar | |
| The companies of the | Examiner | | | | | of): | | | | | | | - <u>-</u> | |
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| FEMALE: 23d. Date of delivery 23d. Date of deliv | e execut sian and rial - tran | | UNPENDED | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | 8760 ificate b ig physic | | 23b. Was decedent pregnant in ti | ha | , - | | tal death 3 | Ectopic | pregnance | v | | - | ay Year | |
| 29b. Signature and title of certifier 29c. License number O.C.M.E. June 16, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | lox 6 eath cert | sicia | | leaning T | | eath 5 Ot | her (Specify) | | | | | | | |
| 29b. Signature and title of certifier 29c. License number O.C.M.E. June 16, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | And the ded by the letached | | Part II. Other significant condit | | | resulting in the u | inderlying cause | given in Pa | rt I. | | | | | _ |
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| 29b. Signature and title of certifier 29c. License number O.C.M.E. June 16, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | Sion ottendin death. ctor: A y the fu | ation | Pen | estigation | | | | | No | | | | | |
| 29b. Signature and title of certifier 29c. License number O.C.M.E. June 16, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | Division Aura after | ertific | dete | id not be | | nome, farm, stree | et, factory, office | building, etc | | or Town, S | tate) | | il Route Number, Ci | ty |
| 29b. Signature and title of certifier 29c. License number O.C.M.E. June 16, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | he Hosp in 24 hor he Fune pletely fi | | 29a. Certifier (Check only 1 Certifying P | - | - | - | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | | Med | | and manner s | | | | | | | | | | |
| Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature | ISH | | In | 1. 11 | | - 22-> | 0.0 | .M.E. | | | June 16, 20 | 12 — | | |
| State 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar 2. Registrar's Signature | | | | | | | Baltimore St | reet, Balti | more, N | 1D 21223 | | | | |
| | | _ | 31. Date filed (Month, Day Year) JUN 252 | 012 Ens | egistrar's Sign | ure park | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jackson Ray 1:15 1 sune 21 7017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 608 Yearling Ct. Severn Anne Arundel 5. Social Security Number If Under 1 Year I if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 230-94-6811 Director txtxt M 2 □ F 54 7/12/1957 VA be filed within /2 incr...
Antal Hygiene.
arked other then "natural", or items 23a or 28a-1 ance.
arke event, the Medical Examinar must be notified at Usual Residence of Decede 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21144 608 Yearling Ct. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1. Yes 2 No 1975—
If Yes, Give Black, White, etc. 1 Never Married 24 Married à Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2√ No Specify. Completed 3 Divorced 1986 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 end 2 should be filed wit Depertment of Health end Mental Hygier Important: If item 27 is merked other to eny injury or other treumatic event, the 2006. Federal Government Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ray Emerson Jackson, Sr. Betty Schrader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, MD 21144 Carolyn A. Jackson Wife 608 Yearling Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery 6/25/2012 Lynchburg, VA Signature of Funeral Septile Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tonque (ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): vsician end burial-transit Hospital or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ettending physician for use es the buria Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day ed by the el ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ å Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificete hes been situated the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural 5 Pending iniury To the Hospital or Attendin within 24 hours efter death.
To the Funerel Director: Aff completely filled in by the fu death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier ns Ry yound MO 29c. License number 29d. Date signed (Month, Day, Year) 00057465

DHMH 17 Rev 06-2011

State

Registrar

2835 Smith /N

32. Registrar's Signature

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Rulhimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S RNJUPAKSEND

JUN 22 2012

31. Date filed (Month, Day, Year)

Please Type or Brint in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Cecil B. Kitts 06:55A Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death

Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 218-20-0516 1 🛛 M 2 🗆 F 86 Yrs Apr. 7 1926 West Virginia Show 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits or 28a-f Rockville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral "natural", or items 23a 20850 13730 Travilah Road United States . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1944 Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 1946 Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72... th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Masonry/Landscaping Brick Mason 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Munsey Shular Kitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code ge 1 and 2 sh nt of Health a : If item 27 is 4308 Langdon Drive, Mt. Airy, Maryland 21771 Brenda Kitts Conover/Daughter Baltimore, 20a. Method of Disposition Page 1 a 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place injury or 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 06/11/12 Darnestown, Maryland Darnestown Presbyt. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Laytonsville, Maryland Box 5038, 20882 P.O. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Physician/ Cardio-respira disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** + ic Sequentially list conditions, if only leading to harmoullat Sue to for as a non-seque on of cause. Enter Underlying Cause (Disease or injury clostridium sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ρ Pregnant at time of death 5 Other (specify) Month Day Year a Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 MInpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: After 1 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be l in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled 24 hours Medical within 24 hound to the Funer completely fi 🕌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Number 7. The could do my knowledge, seek screen and the time, date and place, and due to the cause(s) and manner ac stated. (Check 0 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 4, 2012

D0065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8x 9901 Rockville, MD 20150 Medical Ctr Br nena 31. Date filed (Month istrar's Signature State 1186 Registrar

0655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Physician/ Medical Examiner 1. Decedent's Name (First, Middle, Last) Norma Jean Kimbrell 4a. Facility Name (if not institution, give street and number) Annapolitan 5. Social Security Number 230-42-0318 1 | 4c. County of Death Anne Arunde1 9. Birthplace (State or Foreign Country) VA 10d. Inside City Limits 1 Yes X No 9. Citizen of What Country? USA 14. Race - American Indian, |
|--|---|
| Physician/ Medical Examiner Norma Jean Kimbrell 4a. Facility Name (if not institution, give street and number) Annapolitan 5. Social Security Number 230-42-0318 Itsual Posidence of Decedant Norma Jean Kimbrell 4b. City, Town, or Location of Death Annapolis Funeral Director 7. Age (In yrs. last birthday) 1 | 4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Country) VA 10d. Inside City Limits 1 |
| Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolitan Annapolis | 4c. County of Death Anne Arunde1 9. Birthplace (State or Foreign Country) VA 10d. Inside City Limits 1 Yes X No 9. Citizen of What Country? USA 14. Race - American Indian, |
| Annapolitan 5. Social Security Number 230-42-0318 It yes Posidere of December Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Hours Min. Months Days Hours Min. 8/29/19. | 9. Birthplace (State or Foreign Country) 35 VA 10d. Inside City Limits 1 Yes XX No g. Citizen of What Country? ' USA 14. Race - American Indian, |
| Tuneral Director 230-42-0318 1 □ M 🖾 F 76 Months Days Hours Min. (Month, Day, Y 8/29/19. | Country) NA 10d. Inside City Limits 1 Yes XX No g. Citizen of What Country? USA 14. Race - American Indian, |
| Heural Basidance of Decement | 10d. Inside City Limits 1 ☐ Yes 🛣 No g. Citizen of What Country? ' USA 14. Race - American Indian, |
| 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Arnold | 1 ☐ Yes 🛣 No g. Citizen of What Country? ' USA 14. Race - American Indian, |
| Anne Arundel Arnold | g. Citizen of What Country? ' USA 14. Race - American Indian, |
| | USA 14. Race - American Indian, |
| 106. Street and Number 1303 Circle DR. 21012 | 14. Race - American Indian, |
| 1303 Circle DR. 21012 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? Armed Forces? | |
| Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Specify: 1 Y | Specify: White |
| 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b.) | 6b. Kind of Business/Industry |
| College (1-4 or 5+) Fig. 2 | Own Home |
| N S S S S S S S S S S S S S S S S S S S | |
| Elery Loyd Della Mae VanSt | avern |
| 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C | |
| Benjamin Kimbrell, Jr. Son 1303 Circle Dr. Arnold, MD 210 | 1 Z 0c. Location - City or Town, State |
| The state of the | Arlington, MD |
| The property of the property o | neral Home, P.A. |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. | |
| Ph_ician/ Immediate Cause (Final disease or condition Multiple Myeloma | Onset and Death William |
| Medical resulting in death) Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate Due to for as a consequence of the conditions of the conditi | |
| Sequentially list conditions, if any, leading to make a consequence of: Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | |
| resulting in death) Last Due to (or as a consequence of): | |
| cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | |
| D W IF FEMALE: 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
| The state of the s | Month Day Year |
| O to the page of t | acco use contribute to the cause of death? |
| Dementia, Anemia | s 2 No 3 Probably 4 Wunknown |
| The second of th | 24b. Were autopsy findings available |
| 24a. Was an autopsy per or compared to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | ed? death? |
| The second secon | |
| Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resider | |
| 27. Manner of Death 27. Manner of Death 28c. Injury at work? 28d. Describe how work work work work work work work wo | Injury occurred |
| O E de l'ét 2 Accident Investigation | eet and Number or Rural Route Number, State) |
| o to | se(s) and manner as stated |
| 29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the control of the control of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the control of the control of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the control of the best of my knowledge, death occurred at the time, date and place, and due to the cause of the control | place, and due to the cause(s) and manner stated. |
| P ≥ P Signature and title of certifier 225. License number 225. License number 225. | d. Date signed (Month, Day, Year) |
| Rita Bhawan, MD D0062534 | 6 31 2012 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA DHAWAN, MD 9055 CHEVROLET DRIVE, SUITE 103, E | LI WIT CITY, MD-21042 |
| State Registrar 31. Date filed (Month, Day, Year) JUN 2 2 2012 32. Registrar's Signature | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 2012 July Physician/ Harold Dorsey Kehne 1 1:51A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 220-16-3358 86 Hours Min. **Director** Dec. 8, 1925 Mary land Usual Residence of Decede 28a-f show 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number U.S.A. 10f. Zip Cod 21701 Funeral 912 Cherokee Trail within 72 hours after death Armed Forces?

1XX Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. ☐ Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental I permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ralph Stanley Kehne Pauline Elmyra Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 13 Kline Blvd., Frederick, MD 21701 David A. Kehne, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery July 6, 2012 Frederick, MD 21. Signature of Funeral Service Line Lee ²Keenev⁴and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Part 1. Enter the disease, or complicat shock, or heart failure. List only one car is that caused the duath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Operand Death Immediate Cause (Final ndioVascular Ph_sician/ disease or condition Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pue to for as a consequence of Exami burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🔲 Yes been si Completed No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ✓ No 24a. Was an has page 2 autopsy perform this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
injury 28c. 2 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my inowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 2 29c. License number 29d. Date signed (Month, Day, Year) Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1100 Medical (if not institution, give street and h Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 6 Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min 220-28-7771 1 □ M 2 🛛 F 81 **Director** 04/06/1931 PA 28a-f show 10c. City, Town or Location 10d. Inside City Limits at Director or than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified MD Carroll Westminster 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 303 Wayne Avenue 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc 1 Never Married 2X Married b within 72 hours after Maryland 21215-0036 1 Yes 2X No Specify: White Yes. Give Specify. 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Robert Moffett Erma Schreiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lewey King/husband 303 Wayne Avenue, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Paul's Lutheran 06/27/2012 New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Apristissing uneral Home and Chapel, PA Signature of Funeral Service Licensee will 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the t IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 1 Yes 2 D the be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably Unknown cate has been sig page 2 should t 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perform death? 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital Other: 2 🗌 No ၉ 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural 5 Pending injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Krechman A^{M} Lorraine June 2012 2:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charles Waldorf 114 Garner Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF (Month, Day, New York 1943 Director 127-32-3848 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Waldorf Charles 1 🗌 Yes 2 💢 No MD 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral Garner 20602 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. H&R Block Tax Preparer is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ပ Tremblay Mabel Joseph Metzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Kim Klein/Daughter 5760 Moss Rock Way, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 07/06/12 Alexandria, VA Crematory Metro. 22. Name and Address of Facility Raymond Funeral Service, PA Signature of Funeral Service Lic MO1517 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ aV disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Yes 2 No 9 Unknown tor: After this certificate has been signed by a the fureral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manger of Deat 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Dir ctor: A 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in 3y determined Medical 1-Fritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this optimization, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

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31. Date filed (Month, Day, Year) **JUL 1 2 2012**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bryan Lethbridge 1850 Louise 12 me 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Brooke Grove Assisted iving-was lontgomery If Under 24 Hrs: Date of bill. (Month, Day, Year 26 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Months Davs Hours 215-38-3190 100 Director Sept. Maryland Usual Residence of Decedent ms 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. That It if item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1143 Baltimore Annapolis Blvd. 21012 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify If Yes, Give Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bryan Lillian Milstead Elis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Duncan/Daughter 1143 Baltimore Annapolis Blvd., Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 06/18/12 Burtonsville, Maryland 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee P.O. Box 5038, Laytonsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ gangrene x weeks disease or condition Medical resulting in death) Examiner anetes 100G Sequentially list conditions, if my leading to immediate cause. Enter Underlying Examiner Due to lor as a consuluence of Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Itending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year ed by the g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be der Certificate: To Be Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred : After 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20860 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2246P M Litman Litow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death REGIONAL Medral Costa NICOMICO PENINSULA 314136414 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 222-18-4935 Director 1 X M 2 D F 90 03/03/1922 Poland Usual Residence of Decede show 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits 28a-f Direct Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number ö 10f. Zip Čode 10g. Citizen of What Country? 23e Funeral 1012 Evergreen Ave 21801 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 K Married ៰ δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) af Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Grower Poultry Be treumatic event, 17. Father's Name (First, Middle, Last) rmit. Page 1 and 2 should be filed partment of Health end Mental Horostent: If item 27 Is marked out winjury or other treumatic evem 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Moshe Zev Litowarski Devora (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Litow/Son 4202 Falconwood Place, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XI Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 6/24/2012 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Sign ture of Funeral Service Licensee Nombook 9 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) Examine Due to (or as a consequence of): rsician end Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physicien: The law requires that the death certificete be Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ò in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No be detached 9 Unknown of Vital Records, P.O. ć Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> cate has been signated the page 2 should the Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate to completely filled in by the funeral director, pag. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred M Natural 5 Pending Division Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United The Cause (s) and manner stated The time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 00 OTC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shune State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Barbara June 22, 2012^{Year} T.ee Lohr 9:55 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hospice-Casey House Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Year) Country Director 212-66-8926 1 □ M 2 🖾 F July 22, 1931 GA Usual Residence of Deced 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2904 N. Leisure World Blvd. #407 20906 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify:White If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: 3 ™ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard W. Bray Allie Margaret Bramblett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Lee Roemer/Daughter 3631 Gregg Road, Brookeville, MD 20833 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. W, Si . Signature of Funeral Service Licen Home Inc. Lver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non-Small Cell Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence HOSPICe 6 Other (Specify) မ 1 Tes 2 (XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral r 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accider
3 Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 10 June 23, 2012 30. Name and address of person who completed caused death (Item 23a) (Type, Print) Coleman, 1355 Piccard Drive, #100, Rockville, MD 20850 MD 31. Date filed (Month, Day, Year) State 2012 JUN 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 24, 2012 **Physician** 10:30 Dorothy Leanora Lehman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Burnett Calvert Hospice House Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 11/19/1938 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 √2 F Texas 546-50-7783 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the "Nexical Examinat must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Prince Frederick Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20678 United States 282 Cambridge Place 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: Specify: White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Marion Davidson, Sr. Dorothy Ida-Catherine Conway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important; if item 27 Is any Injury or other trau Barbara Lehman / Daughter 282 Cambridge Place, Prince Frederick, Maryland 20678 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitian Crematory 06/26/2012 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, PA 21. Signature of Funeral Service Licensee Kyle S. Simons M012067 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year signed by the a 1 □Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 $\square\,\,$ Other (Specify) Hospice 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? House 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af e Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** 29a. Certifier completely (Check only and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 06/26/2012 ause of death (Item 23a) (Type, Print) 30. Name and address Movimac Ct, Prince Fred, W) drw 32. Regist

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{rear}}{12}$ McDowell June 9:40 A^M Molesworth, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Life Center Carroll Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth . Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Days Feb. 3, Year 24 Hours Min. Mary land 217-18-7549 88 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 201 Flower Court 21771 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 ò 1 Never Married 2 Married Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/ President Auto Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Harold McDowell Molesworth Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Flower Court James Molesworth / Son Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 16 1 X Burial 2 Cremation 3 Removal from State Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Mt. Airy, Maryland . Signature | Fun ral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or ilinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No the 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe The law requires Congestive Heart Failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available Chronic Obstructive Pulmonary Disease has prior to completion of cause of death?

1 Yes 2 No autopsy certificate Yes 2 X No Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 24 hours after death. Funeral Director: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0052861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asha vall, 31. Date filed (Month, Day, Year) IIIN 15 2012 12640 Clarksville Pike Clarksville, Maryland 21029 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day} 2012 Physician/ JUNE 11, 8:50 P M MACDONALD MARY LOUISE Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery 4125 Great Oak Road Rockville 5. Social Security Numbe Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 011-16-6755 Director 1 □ M 2 🔀 F Oct. 17 1914 97 Yrs Iowa Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State Director Rockville 1 🗌 Yes 2 🗷 No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 ms 23a o must be Funeral 20853 United States within 72 hours after death with 4125 Great Oak Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed and Mental Hygiene.

is marked other than "natural manatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Law Office Legal Secretary Be traumatic event, Department of Health and Mental Hills Department of Health and Mental Hill Important: If then 27 is marked oth any injury or other traumatin 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame, Leonora Brown ည Grace Abram Sylvanus Woodard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20861 Sandra L. Macdonald 1301 Tucker Lane, Ashton, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 06/15/12 4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Licenses Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Ph_sician/ 4 days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Years Myelodysplastic Syndrome Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death ed by the a detached 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page 2 certificate has 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medica Be Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) nours after death.

neral Director: After this of 2 🔀 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: or Attending 1 🗷 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title f.certifier 29d, Date signed (Month, Day, Year) D2105 14 6 12

Registrar

DHMH 17 Rev 06-2011

3

State

31. Date

3300 Olney-Sandy Spring Rd., Suite 330, Olney, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Jonathan Maltz,

iled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #5perFH, 6/28/12; AMEND For AMEND #Openth, 0/20/14, 1337, 2000 State AMEND#19apenth, 6/28/12; HWW, MoCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 6:00 рм På 2012 Beruce Maclennan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery 085-26 -1504 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 1 DM 2 XF 92 Yrs March 14.1920 Scotland Usual Residence of Deceder 28a-f shov 10a. State ir then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Bethesda 1 Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 U.S.A. 6307 Crathie Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 XWidowed 4 Divorced Specify: Completed Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mental Health Psychologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of ပ္ (Unascertainable) (Unascertainable) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic other traumatic Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Personal Rep. 6709 Selkirk Drive, Bethesda, Maryland 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory: 06/28/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee m01024 22. Name and Address of Facility
Simple Tribute Funeral & Cremation Center al *⊶*ہ ک 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failbre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Small Bowel Obstruction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pur Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-Physician/Medical Box 68760 as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Dementia Completed 1 Yes 2 X No 3 Probably 4 Unknown been si Coronary Artery Disease Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Paroxysmal Atrial Fibrillation certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 ☐ Yes 2 🗓 No မ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R143201 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State JUN 25 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:07PM RICHARD T. MARSHALL JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 217-32-6580 Director 1 🕅 M 2 □ F Maryland March 16,1935 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Washington County Boonsboro 1 🎇 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "natural", or items 23a Funeral 7 Maple Ave. 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Was Deceden 2 Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 X Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "any injury or other traumatic event. the Mex-Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Maintenance Foreman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Eaton Luther Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Maple Ave. Boonsboro, MD 21713 Pearl A. Marshall-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 7-3-2012 Sharpsburg, MD Mt. View Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Opermonia Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialsigned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 2 No unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hospital or Attending Physician; The law has performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ Manpatient 2□ ER/Outpatient 3 DOA this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely i 3 🗆 only one) 29b. Signature and title of certifier 77476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff Komirant NO 400 W.75

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signature

| 2-04902 | Please Type of Print in Black indelible link. Ensure All Copies Are Legible. | | |
|-----------------------|--|------|-------|
| Crescent Carol Martin | State of Maryland / Department of Health and Mental Hygiene | 2012 | 22020 |
| 1- For State | Cortificate of Dooth | 4016 | |

| Physicia | | Registrar | | rtificate o | Dodan | | | Reg. No. | | | | |
|--|--|---|--|---|---|--|--|---|--|---|--|--|
| | | Decedent's Name (First, Middle,Last) | | | | | 2. Date of De Month | | ear | 3. Time of Death | | |
| ledical Exami | ner | | Carol Mar | | | | June 30, | 2012 | | 1614 hrs | | |
| | | 4a. Facility Name (if not institution, give str | reet and number) | | 4b. City, Town, or Lo | ocation of Deat | h | 4c. County | | | | |
| | | 18765 Penn Shop Road | | | Mount Airy | | | Howard | | | | |
| Funeral | | Social Security Number 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 Year | If Under 24Hr | _ | of Birth (MM/DD/YYYY) 9. Birthplace (State or | | | | |
| Director | | 217-94-1770 ¹□M | 2XF 38 | Yrs | Months Days | Hours Min | | 14, 197 | 3 Co | Mashington DC | | |
| | | Usual Residence of Decedent | 1 30 | | | | 1001 | - · · · · · · | | | | |
| any | | 10a. State 10b. County | 10c. City, | Town or Local | tion | | | | | 10d. Inside City Limits | | |
| P P P | _ | Maryland Howard | | Mount | Airv | | | | | 1 Yes 2 No | | |
| Maryland 28a-f show 1 at once. | 용 | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Cour | ntry? | | |
| ne Mary or 28a | Director | 19765 David Char D | 1 | | 0177 | , 1 | | *** | 1 0. | | | |
| th th noti | | 18765 Penn Shop R | | C 140.144 | 2177 | | `i6 . V N | Unite | | | | |
| th w | Funeral | 11. Marital Status 1 X Never Married 2 Married | Was Decedent Ever in U. Armed Forces? | | as Decedent of Hispa Yes, specify Cuban, N | | | | ite, etc. | can Indian, Black, | | |
| or it | 큔 | 1 | Yes 2 X No | l | 1 v ~ [V] v | | | 0 | τ. | The | | |
| ırs afte ural", miner | ò | | Dates: | 1 | Yes 2 X No | | | Specify 16b. Kind of E | | White | | |
| hour | | 15. Decedent's Education (Specify only h | susiness/i | ndustry | | | | | | | | |
| 215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. "matural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. | Completed | Elementary/Secondary (0-12) | l | | | | | | | | | |
| 5-00; lled withi Hygiene. I other ti | E | | 12 | Wa | aitress | Banthada Blass | - (First Middle | FOOd a | | leverage | | |
| d oth | | 17. Father's Name (First, Middle, Last) Edward Leroy Sell | ie) | | | | | | | | | |
| 21215-0036 ould be filed within 7 i Mental Hygiene. marked other than ic event, the Medica | Be c | 01-1- | 7(-, 0) | | | | | | | | | |
| Shoul shoul and N | Edward Leroy Sellers 19a. Informant's Name/Relationship (Type, Print) Lynette A. Browning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S Lynette A. Martin / Mother 18763 Penn Shop Road Mt. Airy, Maryl. 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Statur of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Ho 8 E. Ridgeville Blvd. Mt. Airy, Maryl. | | | | | | | | | | | |
| MD nd 2 sho alth and m 27 is | | | | | | | | | | | | |
| s a s la | | 1 X Burial 2 Cremation 3 | | crematory or ot | | | ı1y 10, | 200. Eddallor | i - Oily oi | Town, State | | |
| Page rent c | | | | | | | | | | Maryland | | |
| Baltimore, permit. Pages I an Department of Hea Important: If ite | | 21. Sanatur of Funeral Service Licensee | | 22. N | Name and Address o | Facility St | auffer | Funeral | Home | es, P.A. | | |
| E.F.C.E. | | weget | | 8 I | E. Ridgevi | 111e B1 | vd. Mt | . Airy, | Mary | land 21771 | | |
| Physician | | 23a. Part I. Enter the disease, or complicate failure. List only one cause on each I | | Do not enter t | the mode of dying, su | ich as cardiac | or respiratory ar | rest, shock, or h | eart | Approximate Interval Between Onset and | | |
| ୍/Medical | | • | Dilated Cardi | Lomvoda | ıth v | | | | | Death | | |
| Examiner | ı | | e to (or as a consequence of | | | | | | | | | |
| | | Sequentially list conditions, b | | | | | | | | | | |
| | ē | | e to (or as a consequence of |): | | | • | | | | | |
| | Examiner | (Disease or injury that initiated C. | e to (or as a consequence of | 6)- | | | | | _ | | | |
| ted J | Ä | events resulting in death) Last d. | 7 to (c. do d contradaction of | , | | | | | | | | |
| executed an and al - trans | n/Medical | | MENDED 23a,27 | per me | g930 8-24 | 4-12 vt | | | | | | |
| 3ox 68760, death certificate be attending physici I for use as the buri | B | | 23c. If yes, outcome of pregr | | 8,30 0 2 | . 12 10 | | 23d. Date of | of delivery | | | |
| 8760, tificate bung physic | | 23b. Was decedent pregnant in the | 1 Live birth | | etal death 3 | Ectopic pregn | ancv | Month | of delivery | ay Year | | |
| cerdinase a | 흥미 | past 12 months? | | 🗀 | | | | 14101101 | D | | | |
| | .= 1 | | 4 Pregnant at time of dea | ath 5 ot | | | unoy | World | D | , | | |
| Boy death he att | ysi | 1 Yes 2 No 9 Unknown | 4 Pregnant at time of dea 9 Unknown | ath 5 Ot | ther (Specify) | | | Nona T | D | 1 | | |
| O. Box at the death of 1 by the atten tached for us | / Physicia | 1 Yes 2 No 9 Unknown Part II. Other significant conditions con | 9 Unknown | | ther (Specify) | en in Part I. | 23e. Did | tobacco use con | tribute to | the cause of death? | | |
| P.O. Boy es that the death signed by the att be detached for | Š | | 9 Unknown | | ther (Specify) | en in Part I. | 23e. Did | tobacco use con | tribute to | 2.5 | | |
| ds, P.O. Boy requires that the death oeen signed by the att ould be detached for | Š | | 9 Unknown | | ther (Specify) | en in Part I. | 23e. Did 1 Ye 24a. Was | tobacco use con es 2 No 3 | tribute to to | the cause of death? ably 4 Unknown topsy findings available | | |
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| tal Records, P.O. Boy cian: The law requires that the death certificate has been signed by the att ector, page 2 should be detached for | Completed by | Part II. Other significant conditions con | 9 Unknown Intributing to death but not re | esulting in the u | underlying cause give | f Death (Check | 23e. Did 1 Ye 24a. Was auto perfr 1 Yes only one) | tobacco use con is 2 No 3 is an psy primed? 2 No | tribute to to a Prob Were aut prior to co death? | the cause of death? ably 4 Unknown topsy findings available ompletion of cause of s 2 No | | |
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| Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death To the Funeral Director: After this certificate completely filled in by the funeral director, page | Certification: To Be Completed by | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On and 29b. Signature and title of certifier 30. Naha and address of person who com | 9 Unknown Intributing to death but not re poital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho (Specify) To the best of my knowledge the basis of examination and manner stated. Inpleted cause of death (Item the Medical Examiner) | ER/Outpatient 28b. Time of I ome, farm, stree | 26.Place of t 3 DOA Office build rived at the time, date tion, in my opinion, d 29c. License r O.C.M. | f Death (Check ther4 Nursi at Work? s 2 No iding, etc. and place, and leath occurred | 23e. Did 1 Ye 24a. Was auto perfit of the perfit operfit ope | Residence 6 how injury occu (Street and Num State) and place, and 29d. Date sig | tribute to to a probability of the control of the c | the cause of death? ably 4 Unknown topsy findings available ompletion of cause of s 2 No Scene ral Route Number, City add. a cause(s) | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State | State of Ma | aryland | | rtment tificate | | | nd Mer | | 1 | 012 | 22021 | | | | |
|----------------------------|--|--------------|--|--|----------------|--------------------------------|---|-------------------------|-------------------------------|----------------------------|--------------------------------|-------------------------------|------------------------------|--|--|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last |) | | Ceri | mcate | OI D | eaur | 2. | Date of Dear | th | | 3. Time of Death | | | | |
| П | Physicia Medic | | Tania Danelle Madd | len | | | | | | J | Month une | 19 ^{Day} | $2\check{0}^{ear}2$ | 5:56 A M | | | | |
| - No. | Examin | | 4a. Facility Name (if not institution, give s | , | | | | , | ocation of I | Death | | 4c. County of Death Frederick | | | | | | |
| أمر | | | Kline Hospice Hous 5. Social Security Number 6. Security Number 16. Security Number 1 | | e (In yrs. las | st hirthday) | If Under 1 | | Airy If Under 24 | | Date of Birth | | | | | | | |
| | Funeral Director | | | _ M 2 X F | 40 | Yrs. | | Days | | Min. | (Month, Day, | Year) | Coun | | | | | |
| | d woi | Ļ | Usual Residence of Decedent 10a, State 10b, County | | 10c City | , Town or Loc | ation | | | | 00. 12 | , 17/1 | | Od. Inside City Limits | | | | |
| | arylan ka-f sh ified a | Director | Maryland Freder | ick | 1001011, | | rederi | ick | | | | | | 1 XX Yes 2 □ No | | | | |
| | the N | | 10e. Street and Number | 10f. Zip C | | | | | 10g. Citizen o | | • | | | | | | | |
| | within 72 hours after death with the Maryland gient grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at | Funeral | 3019 Cloister Way | | | 1 | <u> </u> | 217 | | 2 (2) | | | ed St | | | | | |
| (0 | er deat or iter niner | | 11. Marital Status 1 | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 | | . 13. W | as Deceder Yes, specify | nt of His Cuban | panic Origin , Mexican, F | 1? (Specify Puerto Rica | Yes or No- an, etc.) | | ce - Americ ack, White, e | | | | | |
| 036 | irs afte ural", I Exan | Completed by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates. | 110 | 1 | ☐ Yes 2X | ⊠ No | Specify: | | | Specia | y Whi | e | | | | |
| 15-(| 72 hou r"nat | nple | 15. Decedent's Ed (Specify only highest grad | | | 16a. Deced | ent's Usual (ind of work of NOT use re | done du | tion uring most o | of working | | 16b. Kind of | Business/Ind | dustry | | | | |
| 212 | iled within 73 Il Hygiene. I other than vent, the Me | | Elementary/Secondary (0-12) | College (1-4 or 5 | 5+) | | tress | | ager | | | Resta | urant | | | | | |
| Maryland 21215-0036 | iled I Hy oth | To Be | 17. Father's Name (First, Middle, Last) | | | | | | | | rst, Middle, M | Maiden Surnar | ne) | | | | | |
| ryla | ould be file nd Mental I marked o | | Thomas David Madde | | | 401-14-25- | A -1-1 (C | | | - | | | 04-4- 7:- 0 | | | | | |
| Ma | 12 sho alth an 27 is ir trau | | John Rosarius / St | | | 3019 | Clois | ter | Way, | Frede | erick, | MD 21 | 701, Zip C | .caej | | | | |
| Baltimore, | of Head of Hea | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | Removal from State | | ace of Dispos emetery, crem | | |) .Tı | une 2 | 1. | 20c. Location | - | | | | | |
| ţi | t. Pagartment rtant: rjury c | | 4 Donation 5 Other (Specify | | Res | thaven | | | У | 201 | 2 | | | laryland | | | | |
| Bal | permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once. | | 21. Signature and eral Service Licens | | | Re 195 | Name and sthave 01 Cat | Address en F toct | of Facility unera in Mo | l Ser untai | rvices In Hwy | , Skkot . Frede | Cody | P.A. MD 21701 | | | | |
| | | | 23a. Part 1. Enter the disease, or comp shock, or beart failure List only on | lications that caused e cause on each line | the death. | | | | | | | | | Approximate Interval Between | | | | |
| 4 | Medical | 8 4 | Immediate Cause (Final disease or condition resulting in death) | Metasta | | | Cance | r | | | | | m | onths-yrs. | | | | |
| , t | Examiner | | | Due to (or as | a conseque | ence ot): | | | | | | | | | | | | |
| | _ # | iner | Sequentially list conditions, if any, leading to immediate | Due to (or as | a conseque | ence of): | | | | | | | | | | | | |
| | ecutec and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | a conseque | ence of): | | | | | | | | | | | | |
| 0 | death certificate be executed re attending physician and ed for use as the burial-transit | dical | | d. | | , | | | | | | | | | | | | |
| 68760 | ificate ng phy as the | Med | IF FEMALE: | u | | | | | | | | | | | | | | |
| 9 X | th cert ttendir or use | ian/ | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome | 2 Fetal | death 3 | | | | | | | ate of delive | ery Day Year | | | | |
| _ | he dea y the a | Physician/Me | 1 ☐ Yes 2 🕮 No 9 ☐ Unknown | 4 ∐ Pregnant a 9 ☐ Unknown | t time of de | eatn 5 L | Other (spec | ciry) | | | | | | | | | | |
| | s that the death certifica igned by the attending p be detached for use as ' | by P | Part II. Other significant conditions co | ntributing to death b | ut not resu | Ilting in the ur | nderlying car | use give | en in Part I. | | | | | e cause of death? | | | | |
| rds, | requires been sig should b | ted | | | | | | | | _ | 1 🗆 Y | | | pably 4 Unknown | | | | |
| 900 | has by ge 2 st | Completed | | | | | | | _ | | 24a. Was a autop: perfor | sy | | osy findings available mpletion of cause of | | | | |
| = B | sician: The la certificate ha rector, page | | 25. Was case referred to medical | | | | | 26. Plac | ce of Death | (Check on | 1 Yes | | 1 Yes | 2 No | | | | |
| Vita | Physicia this cert ral direct | To Be | examiner? 1 ☐ Yes 2 🏧 No | lospital: 1 | ent 2 🗆 E | ER/Outpatien | | Other | | | | ence 6 🗷 Ot | her (Specify | Hospice House | | | | |
| Division of Vital Records, | Attending Physician: The law requires and added: ctor dath. ctor dath. by the funeral director, page 2 should be | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of inju (Month, Day | | 28b. Time of injury | | . Injury work? | ar | 280 | . Describe ho | ow injury occu | rred | | | | | |
| sior | l or Attenc after death Director: / | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Inju | ury - At hon | ne, farm, stre | et, factory, c | | ′es 2□N | | Location (Si | treet and Num | ber or Rural | Route Number, | | | | |
| | tal or after all Direction in the control of the co | | 4 - nomicide detentimed | building, etc | . (Specify) | | | | | | City or Town | n, State) | | | | | | |
| | To the Hospital or Attending Physician: Within 24 hours after death after this certific To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | 29a. Certifier 1 X Certifying Phys (Check 2 Medical Examir only one) 3 Certifying Nurs | ner: On the basis of e | xamination | and/or investi | gation, in my | y opinion | , death occu | urred at the | time, date ar | nd place, and d | ue to the cau | use(s) and manner stated. | | | | |
| | To the I within 2 To the I complet | 2 | 29b. Signature and title of certifier | - raculoner: 10 th | o pear of III | y Kilowieuge, | 29c. L | icense | number | and prace, | 2 | 29d. Date sign | ed (Month, I | Day, Year) | | | | |
| | | | 1 9 | 1 | | | | . UU | 61961 | | | June 20 | , 201 | 2 | | | | |
| | 6 | | 30. Name and address of person who con Sadat Taimur, M.D. | | | | | ive | Fred | leric1 | k. MD | 21702 | | | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Redistra | | ure | | | , | | , 110 | | | | | | | |
| | Registra | | JUN 2 2 20 | 112 Janes | and a | A. 1 | arked | | | | | | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Lee Mason 06/5035075 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Hospital Ft. Washington Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 f 240-66-4567 68 10/31/1443 Director Yrs. Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Charles Waldorf 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 2624 Stanford Pl. 50707 **AZU** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. ò Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Federal Government IRS Auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tessie Simmons Earl Wesley Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2624 Stanford Pl., Waldorf, MD 20601 Sharon Mason / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State = 5 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or once, 07/03/20/2 Arlington, VA Arlington Nat'l Cem 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd∙ Camp Springs MD 20748 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between k, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ANOYIL Physician/ disease or condition resulting in death) IKALOR Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the hurial To Be Completed by Physician/Medical Box 68760 the use as yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month signed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗀 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 002626) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M(D) 11711 Livingston Rd., Ft. Washington, MD 20744 <u>Samuel Keliman,</u>

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20112 Milton Meadows Jr. June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Regional Hospita aurel Prince George's dure 1 Year If Under 24 Hrs. Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Months (Month, Day, Year) Director 285-54-5667 1 X M 2 D F Yrs 57 Feb. 10. 1955 Alabama Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4675 Plymouth Circle 20602 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Noivorced Specify: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 I n and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Meadows Barbara Jean Culpepper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is Shawntay N. Fields - Daughter 160 Fox Glen Drive East Pickerington, OH 43147 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a Important: If it any injury or c cemetery crematory or other place)
Dayton
National Cemeter Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2012 Cemetery Signature of Funeral Service Dcensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John 20019 M00560 4001 Benning Road NE Washington, DC Kewar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Infarction Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 L P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsy 2 🗌 No __ Yes 1 🗌 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of eral Director: After tilled in by the funer. Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation Accident □ Accider
 □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature y p completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency Dept. U 7300 Van Laurel,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1:40 рм Physician/ 2012 Reina Theresa Morin June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Harmony Hall If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 88 025-16-9016 1 □ M 2🛣 F Director MA 05/23/1924 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland **Funeral Director** 1 🗆 Yes 2 No Columbia notified 28a-f MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō pe United States 23a with 21044 Apt. 361 6336 Cedar Lane permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "fratural", or items any injury or other traumatic event, the Medical Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status med Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Weight Watchers Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche Gregoire 2 Alphonse Charest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12113 Blue Paper Trail Columbia Gisele Morin-Connolly / Dau. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3X Removal from State 7/3/2012 Fall River, MA 4 ☐ Donation 5 ☐ Other (Specify) Notre Dame Cemetery 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Si natur of Funeral Service Luinsee Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D. t. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day be detached for Pregnant at time of death the 8 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform 1 🗌 Yes 2 🗌 No 1 Yes 2 No 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medica 6 X Other (S) 1 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 유 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: work? iniury 5 Pending 2 🗌 No after death. Accident Investigation Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

V

State

31. Date filed (Month

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 ear June Delanta J. Mills 23, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4691 Church Road Prince Georges Bowie If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) **Director** 213-82-3061 1 ★ M 2 □ F 51 March 9,196 Wash.,DC Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 13215 10th Street 20715 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 X Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Photographer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Delanta J. Mills Sr Alice Briley 1 and 2 should the Health and Meritem 27 is mark 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Mills/mother Bowie MD

20b. Place of Disposition (Name of 20715 MD item 20a. Method of Disposition 6/30/12 permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial <u>Park</u> Landover, MD Edwards F.H. 21. Signature f Funeral Service License 22. Name and Address of Facility Hodges & 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest is hock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed and -trar Due to (or as a consequence of): attending physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, or Attending Physician: The law requires Completed 1 ☐ Yes 2 ➡ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death?

1 Yes 2 No s certificate has director, page 2 1 Yes 2 4 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 🗆 No Farm မ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying House Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certific 29d. Date signed (Month, Day, Year) D45660 M son who completed cause of death (tem 23a) (Type, Print), CALCANT fex LN 124, Bowie nD 2015

State Registrar JMC4, MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daniel Martin $\mathbf{J}\mathbf{u}\mathbf{I}\mathbf{v}$ 2:45 A. M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18012 Westfield Dr. Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours I Min 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Maryland 1 X M 2 - F 220-30-7784 84 1928 **Director** Jan . Usual Residence of Decedent or 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗷 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 23a 18012 Westfield Dr. 21740 U.S.A. and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 9 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grain Elevator Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ Amos E. Martin Ruth N. Strite traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna L. Martin/Sister f Health aitem 27 i 18012 Westfield Dr. Hagerstown, MD. 21740 or other 20a. Method of Disposition Reiff Mennonite Church 7/5/2012 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 X Burial 2 Cremation 3 Removal from State Hagerstown, MD 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Zimmerman ANd Son Funeral Home Ind. 45 S. Carlisle St. Greencastle, PA 17225 23a, Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition Onset and Death Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Year 5 Other (specify) detached the sate has been signed by page 2 should be detacl Part II. **Other significant conditions** contributing to death <u>b</u>ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes funeral director, 25. Was case referred to ma Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify, 1 Yes 2 🗶 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Miller Month Mildred Physician/ July 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Charles County Nursing La Plata Center If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 84 **Director** 170-22-1262 1 M 2X F 09/24/1927 PA Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f sho ner must be notified at Director Waldorf 1 Yes 2 XNo MD Charles 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 2246 Mattawoman/Beantown 20601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 0 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White If Yes. Give 3 Widowed 4 Divorced ted Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complet 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sewing Machine Operator Behleon Togs Co. the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mable Sarah Rubright William Ephraim Engle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2060 1 Page 1 and 2 shment of Health a 2246 Mattawoman/Beantown Rd., Waldorf, MD Donna Bryan/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 07/14/12 | Allentown, PA Cedar Hill Memor. 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRaymond Funeral Svc., 21. Sigrature of Funeral Service Licensee 5635 Washington Ave., La Plata, MD 20646 M01517 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death loralor acc Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above. P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🔲 only one) 29b. Signature and title of certifier 1199

-6 M

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of leath (Item 23a) (Type, I) I JOS (In VG 2hcy) DI WY, 6934 F

Registra 's Signature

Aviotion Blud, GlenBurnie, MD, 21061

| 2-04787 | | | | | lible Ink. Ensu | | | ible. | | | | |
|--|----------------|---|------------------------------------|--------------------|--|-----------------------------------|-----------------------------|-------------------------|---|--|--|--|
| Patricia Moore | | | of Maryland | | nent of Health ar | nd Mental Hyg | giene | 20 | 2 2202 | | | |
| | | I- For State Registrar | | Certific | cate of Death | | Reg | . No. 20 | 2 2 2 0 2 | | | |
| Physicia | n/ | Decedent's Name (First, Middle,Last) | | | | 2 | Date of Death Month | Day Year | 3. Time of Death | | | |
| Medical Examin | ıer | PATRICI <i>A</i> | MOORE | | | | June 25, 20 | 12 | 1707 hrs | | | |
| | | 4a. Facility Name (if not institution, give | street and number) | | | r Location of Death | | 4c. County of Dea | ith | | | |
| | | 18219 Mason Dixon Road # | ¥14 | | Hagerstow | n | | Washington | | | | |
| Funeral | | Social Security Number 6. Sex | 7. Ag | e (In yrs, last bi | rthday) If Under 1 Ye | ar If Under 24Hrs. | 8. Date of Birth | (MM/DD/YYYY) 9. B | | | | |
| Director | | 232-94-9296 | м 2X F | 54 | Yrs. Months Day | ys Hours Min. | 1/27/19 | 958 Fore | country) WV | | | |
| | ŀ | Usual Residence of Decedent | ··· | - | | | | | | | | |
| any | ŀ | 10a. State 10b. County | | 10c. City, Tow | n or Location | | | | 10d. Inside City Limits | | | |
| | J | WV BERKELE | Υ | HE | DGESVILLE | | | | 1 Yes 2 X No | | | |
| Aaryland 28a-f show Lat once. | 읤 | 10e. Street and Number | | | 10f. Zip Code | - | 100 | . Citizen of What Co | untry? | | | |
| e Ma or 28 | Director | 1096 CONSILER LANE | • | | 2542 | 7 | | JSA | • | | | |
| r death with the Maryland or items 23a or 28a-f sho must be notified at once. | | 44 Marital Otatus | | | | rices Indian Plank | | | | | | |
| th wi | eral | 11. Marital Status 1 Never Married 2 X Married | 12. Was Decedent Armed Forces? | | Was Decedent of His If Yes, specify Cuba | in, Mexican, Puerto Ri | | White, etc. | ace - American Indian, Black, hite, etc. | | | |
| or it | Ĕ | | 0 | ULTE | | | | | | | | |
| s affe | 솔 | 3 Widowed 4 Divorced | or Dates: | aniatad) 116a | 1 Yes 2 X No | | | Specify: V | VHITE | | | |
| hour fratu | 8 | 15. Decedent's Education (Specify only | College (1-4 or | | during most of working life | | | Ob. Killa of East 1995 | an nadou y | | | |
| 36 in 72 han ' | 흶 | Elementary/Secondary (0-12) | College (1-4 of | o+) | HOMEMAKER | | | OWN H | HOME | | | |
| with with Brench | Completed by | 17. Father's Name (First, Middle, Last) | | | | 18.Mother's Name (F | iret Middle Ma | iden Surname) | | | | |
| filed Thys | | JOSEPH T. CRAWFO |)RD | | | , | TY LOCK | | | | | |
| 12 Id be fenta | Be | 19a. Informant's Name/Relationship (Ty | | | 9b. Mailing Address (Stre | | | | to Zin Code) | | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once | 의 | SCOTT D. MOORE/SPC | | ' | 1096 CONSILER | | | | te, Zip code) | | | |
| md 2 salth 2 raum | - | 20a. Method of Disposition | | 20h Place | of Disposition (Name of ce | | | 20c. Location - City of | or Town, State | | | |
| S 1 a of He t | ı | 1 Burial 2 XX remation 3 | Removal from St | ate crema | atory or other place) | JUNE | . 27 | | | | | |
| Pag Pag nent or of | | 4 Donation 5 Other Specify: | | 2MI 1H | SBURG CREMATORY | 201 | .2 | SMITHSBU | RG, MD | | | |
| mit. | ſ | 21. Signature of Funeral Service License | 90 | | 22. Name and Addres | ss of Facility BRO KING ST., M | WN_EUNERA | L HOME, PO | BOX 821. | | | |
| 1 8 2 4 8 | | Kebert C. Fil | les | | | | | | | | | |
| Physician | | 23a. Part I. Enter the disease, or complication. List only one cause on each | | the death. Do r | not enter the mode of dying | , such as cardiac or r | espiratory arres | t, shock, or heart | Approximate Interval Between Onset and | | | |
| /Medical Examiner | | = | | lrug (di | azepam and m | orphine) | Intoxica | ation | Death | | | |
| Examiner | | or condition resulting in death) | ue to (or as a cons | equence of): | | | | | 1 | | | |
| | | Sequentially list conditions, b | | | | | | | | | | |
| | <u>e</u> | if any, leading to immediate cause. Enter Underlying Cause (Discover in light but in littlets) C | | | | | | | | | | |
| | Examiner | | ue to (or as a cons | equence of): | | | | | | | | |
| executed ian and ial - transit | <u> </u> | d. | | | | | | | | | | |
| exec | <u>ह</u> | ■ UNPENDED | AMENDED 23a | ,27,28a | -f,per me,g9 | 30 8-16-12 | 2 sm | | | | | |
| ficate be of physicial the burial | Physician/Med | IF FEMALE: | 23c. If yes, outcor | ne of pregnancy | , | | | 23d. Date of delive | erv | | | |
| ntifica | ٤ | 3b. Was decedent pregnant in the past 12 months? | 1 Live birth | | 2 Fetal death 3 | Ectopic pregnanc | У | Month | Day Year | | | |
| Ox 687 eath certifi | <u>:</u> | | 4 Pregnant at | time of death | 5 Other (Specify) | | | | | | | |
| BC he death the att | إخ | | 9 Unknown | | | | | | | | | |
| that the detach | | Part II. Other significant conditions | contributing to deat | n but not resulti | ng in the underlying cause | given in Part I. | | | o the cause of death? | | | |
| ires that signed the detail | Completed by | | | | | | 1 Yes | 2 No 3 Pro | obably 4 🗹 Unknown | | | |
| ords, w requires been should | | | | | | | 24a. Was an autopsy | | autopsy findings available completion of cause of | | | |
| e law | 티 | | | | | | perform 1 V Yes 2 | ed? death? | | | | |
| tal Rec | | 25. Was case referred to medical | | _ | 26 Plac | e of Death (Check on | | No1 ✓ Y | res 2 No | | | |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. Tal Director: After this certificate has been sided in by the funeral director, page 2 should be a ben of the funeral director, page 2 should be a benefit and the funeral director. | ŭ١ | examiner? | spital: 1 Inpatie | ent 2 ER/0 | Outpatient 3 DOA | Ion | | esidence 6 🗸 Oth | er: Scene | | | |
| Physical direction | 의 | 1 ✓ Yes 2 No 27. Manner of Death | | | | | | w injury occurred | | | | |
| nd of Nding Phylin is After the funeral | Certification: | 1 Natural 5 Pending | 28a. Date of Inju (Month, Day,Y | | 1 | | nknown | | | | | |
| Sic Atter r dear ector by th | <u>ë</u> | 2 Accident Investigation | | | 16:45 pm | | | eet and Number or R | Rural Route Number, City | | | |
| Division pital or Attent ours after death teral Director: filled in by the | 튀 | 3 Suicide 6 K Could not be determined | (Specify) ho | | iam, subst, rasion, smos | | or Town, Stat | te) 18219 Ma | son Dixon Rd. | | | |
| Divisior Hospital or Attend 24 hours after death Puncral Director: seely filled in by the: | | 4 Homicide | | | | | | erstown,MI | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burity | g | (Check only | | | eath occurred at the time, of investigation, in my opinio | | | | | | | |
| To the within To the comple | Medical | | and manner stated. | | 29c. Licen | | | 29d. Date signed (M | | | | |
| | _ | 200. Orginaldre and title of Certifier | / | | | | | | onui, Day, rear | | | |
| 1/ | | Theoley M. K. | in JR. | u.s | , | .M.E. 00N | 15. | June 26, 2012 | | | | |
| D | | 30. Name and address of person who co | | , | -in 000 141 D ::: | | Constant NAT | 04000 | | | | |
| | | Theodore M. King, Jr., MD. | Assistant M | | niner 900 W. Baltir | more Street, Bal | umore, MD | Z 1223 | | | | |
| Sta | ite | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signature | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Jennifer Colleen | | Crone 1- For State | State | of Maryla | and / I | | rtment of | | and | Mental F | lygiene | Ē. | 21 | 7 | 2 2202 |
|--|---|--|-------------------------|------------------------------------|-------------------|------------|-------------------------------------|---------------------------------------|------------|----------------|-----------------|--------------------|----------------------------|--------------|---|
| Physicia | | Registrar 1. Decedent's Name (First, | √liddle,La | st) | | Ceri | uncate of | Dealli | | | 2. Date of | Reg. No | | 2 1 | 3. Time of Death |
| Medical Examin | | Jennife | r Co | lleen M | cCro | ne | | | | | Month June 3 | Da 0, 201 | y Year 2 | | 2018 hrs |
| | | 4a. Facility Name (if not ins | itution, gi | ve street and nu | mber) | | | 4b. City, Town, | or Lo | cation of Deal | h | | 4c, County o | f Death | |
| | | Union Hospital | | | | | | Elkton | · 1 | K 11 0.411 | - lo pata a | f Dinth (a) | Cecil | l o Biw | haloss (Ctate as |
| Funeral Director | 1 | 5. Social Security Number | 6. S | | 7. Age (| | ist birthday) | | ays | Hours Mi | n 1 | | | Foreig | |
| Birector | | 194-42-4274 Usual Residence of Decede | | M 2XF | | 45 | Yrs | | | | 01/ | 31/1 | 96/ | L UP | emhsylvania |
| any | ŀ | 10a. State 10b. Co | | | 10 | Oc. City, | Town or Locat | ion | | | | | | | 10d. Inside City Limits |
| * | ۰ | Maryland C | ecil | | | | E1 | kton | | | | | | | 1 Yes 2 XX No |
| arylar | Director | 10e. Street and Number | | | | | | 10f. Zip Code | 9 | | _ | 10g. (| Citizen of Wh | at Cour | ntry? |
| r death with the Maryland nr items 23a or 28a-f show must be notified at once. | 盲 | 213 Holli | ngsw | orth Ma | nor | | | 2 | 219: | 21 | | U | United States | | |
| n with | Funeral | 11. Marital Status | | 12. Was Dec | | er in U.S | | is Decedent of es, specify Cub | | | | | 14. Race White | | can Indian, Black, |
| r deatl nr ite | 됩 | 1 Never Married 2 | | 1 Yes | 2 X |] No | | | | | - | | | | White |
| rs afte | à. | 3 Widowed 4 15. Decedent's Education | | or Dates: | | eted) | 16a Deceder | Yes 2XX | | | work done | 168 | Specify: b. Kind of Bus | | |
| 2 hou | eted | Elementary/Secondary (0 | | College (1 | | | | ost of working I | | | | | | | |
| 5-0036 lled within 7 Hygiene. Inther than | Completed | 11 | | | | | W | aitress | 5 | | | | Food | vice | |
| 5-0 lied w Hygre Inthe | | 17. Father's Name (First, M | | | | | | | 18. | Mother's Nam | | | en Surname) .nn Owe | | |
| 2121 ould be fi Mental marked ic event, | 8 | Joseph Ba | - | | 11 | | 10h Mailin | Address (St | | | | | | | 7in Code) |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked atthr than "natural", ar items 23a or 28a-f she injury or atther traumatic event, the Medical Examiner must be notified at once | ٩ | Patricia Ann | | | er | | | Willard | | | | | | | |
| e, N I and 2 Health item? | ŀ | 20a. Method of Disposition | | | | | lace of Dispos rematory or other | ition (Name of | cemet | | Date | 20 | c. Location - | City or | Town, State |
| Baltimore, permit. Pages I an Department of He Important: If ite | | 1 Burial 2 X Cren | | | om State | | | Cremat | or | | ly 5, | O N | ewark, | De | laware |
| altir mit. F partme porta | 4 Donation 5 Other Specify 2012 21. Signature of Funeral Service Microsee 22. Name and Address of Facility Crouch Fun | | | | | | | | | | | | ral Ho | me. | P.A. |
| E E G B OO | | should | 1 | | | | | | | ain St | reet,N | orth | East, | Mar | y1and21901 |
| Physician // // // // // // // // // // // // // | | 23a. Part I. Enter the diseas failure. List only one of | | | aused the | e death. | Do not enter t | ne mode of dyir | ng, su | ch as cardiac | or respiratory | arrest, s | shock, or hea | rt | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final dis or condition resulting in dea | ease a | Narcot Due to (or as a | | | | nd Alco |)ho | <u> Into</u> | cicatio | on | | | Death |
| | | | , b | Due to (or as a | consequ | ierice or) |): | | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C | | Due to (or as a | consequ | uence of) |): | | | | | | | | |
| | Examiner | (Disease or injury that Initial events resulting in death) I | ed C | Due to (or as a | consequ | uence of) |): | | | | | | | | |
| cuted md transit | ٥ | | d | l | | | | | | | | | | | |
| (0, e be executed ysician and burial - transit | AMENDED 23a,27,28a-f,per me,g929 7-16-12 sm | | | | | | | | | | | | | | |
| OX 6876C eath certificate attending phys | žΓ | IF FEMALE: 23b. Was decedent pregnan | in the | 23c. If yes, | | of pregn | | tal death | 3 🗍 | Ectopic pregr | ancy | 1 | 23d. Date of o Month | | ay Year |
| x 68 h certi tendin use as | cial | past 12 months? | | 4 Pregn | ant at tim | ne of dea | *h - | her (Specify) | • Ш | zotopio progr | unoy | | MORE | Ü | a, roa |
| Box e death c the atten | Physicia | 1 Yes 2 No 9 ✔ | | 9 OTINIO | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy- npletely filled in by the funeral director, page 2 should be detached for use as the b | D P | Part II. Other significant co | nditions | contributing to | death b | ut not re | sulting in the u | ınderlying caus | e give | n in Part I. | | | | | he cause of death? ably 4 🕶 Unknown |
| ords, P.C. w requires that us been signed the | | | | | | | | | | | 24a. W | | | | opsy findings available |
| Cord law red has be | Completed | | | | | | | · · · · · · · · · · · · · · · · · · · | | | aı | utopsy erformed | pr | | ompletion of cause of |
| Rec The l | 5 | | | | | | | | | | 1 ✓ Y | es 2 | | ✓ Yes | s 2 No |
| ician: s certifi rector, | Be | 25. Was case referred to me examiner? | - | Hospital: | npatient | 2 | ER/Outpatient | | | Death (Check | ng Home 5 | Posi | dence 6 | Othor | |
| n of Vital Records, ding Physician: The law requir . After this certificate has been s funeral director, page 2 should I | ၉ | 1 ✓ Yes 2 No 27. Manner of Death | | 28a. Date | of Injury | | 28b. Time of I | | | it Work? | | | injury occurre | | |
| on conding ath. | cation | | Pending | FA 6 | Day, Year -30- | | fd7:3 | 0 pm 1 | Yes | 2 X No | unkno | wn | | | |
| Division ospital or Attendia hours after death. | fica | 2 Accident 3 Suicide 6 🕱 | Investigat Could not | 29a Place | e of Injury | y - At ho | me, farm, stree | et, factory, office | e build | ding, etc. | 28f. Locatio | n (Stree | t and Number | or Rur | al Route Number, City |
| Div | Certific | 4 Homicide | determine | | F | ound | :in ro | adway | | | Hollin | n, State) | orth M | anoi | al Route Number, City of Elkton, MD |
| Divisior the Hospital or Attend hin 24 hours after death the Funeral Director: upletely filled in by the | | CHECKOIN | - | ian: To the bes | | _ | | | | | | | | | |
| Tn the Hos within 24 h To the Fur | Medical | 1 | | er:On the basis of and manner s | | lation an | | 29c. Lice | | | at the time, d | | | | |
| | 2 | 29b. Signature and title of c | in P | 1 | | | | | c.M.I | | | | uly 1, 2012 | • | th, Day, Year) |
| _/ | ļ | 30. Name and address of pe | rec | acompleted as | 0 05 d = | th (lace t | 222) | | ا ۱۷۱۰ . ب | _· | | | , ., 2012 | | |
| ,0 | | Laron Locke MD. | | tant Medica | | | | altimore Stre | eet, E | Baltimore, | MD 21223 | 3 | | | |
| Sta | ate | 31. Date filed (Month, Day) | ear) | | gistraris | | | - | | | | | | | |
| Regist | 2.1 | JIMI I Z ZU | 16 / | Masser | 4. | 1000 | Wille | | | | | | | | |

OCME

12-04706 Earl Lee Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| te of Maryland / Department of Health and Mental Hygiene | 2012 2 | 2026 |
|--|--------|--------|
| Certificate of Death | 2012 2 | _ とりりし |

| | | r- For State Certificate of Death | Re | eg. No. | 1 = = = 0 0 | | | | | | | | | |
|--|--|---|--|---------------------------|---|--|--|--|--|--|--|--|--|--|
| Physicia Medical Examir | n/ | 1. Decedent's Name (First, Middle,Last) Earl Lee Martin | 2. Date of Deat Month June 22, 2 | Day Year 2012 | 3. Time of Death 1534 hrs | | | | | | | | | |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 315 Hollingsworth Manor Elkton | | 4c. County of De Cecil | eath | | | | | | | | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs | | th (MM/DD/YYYY) 9. | | | | | | | | | | |
| Director | | 215-08-9898 1 N 2 F 28 Yrs. Months Days Hours Min. | 05/29 | 7/1984 | reign ^{Country)} Mary1and | | | | | | | | | |
| > | Ì | Usual Residence of Decedent | | | 10d. Inside City Limits | | | | | | | | | |
| W 20 y | | | | | 1 X Yes 2 No | | | | | | | | | |
| Maryland 28a-f show d at ooce. | 흱 | Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code | 110 | og. Citizen of What C | ** | | | | | | | | | |
| ne Mau or 28 | Director | 315 Hollingsworth Manor 21921 | | United States | | | | | | | | | | |
| | | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. | | - 14, Race - Ar | merican Indian, Black, | | | | | | | | | |
| death or iten | Funeral | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto | Rican, etc.) | White, etc | | | | | | | | | | |
| s after | | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v | work done | Specify: W | | | | | | | | | | |
| 11215-0036 Id be filed within 72 hours after Aental Hygiene. aarked other than "natural", event, the Medical Examinee | Completed by | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | | | | | | | | |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | 힐 | 11 Construction Mainten | nance | Constr | uction | | | | | | | | | |
| 5-0 illed w Hygie I other | | 17. Father's Name (First, Middle, Last) 18.Mother's Name | | | - | | | | | | | | | |
| | 8 | William Earl Martin Kim Lec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F | e Ann Sr | | tota Zin Coda) | | | | | | | | | |
| re, MD 21 I and 2 should Health and Mer fitem 27 is man | 욘 | Kim L. Jourdan/Mother 59 Rhode Island Avenue | | | | | | | | | | | | |
| E, N I and 2 Health item 2 | ŀ | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, | Date 11y 2, | 20c. Location - City | | | | | | | | | | |
| MOF ages ent of nt: If | | |)12 | West C | hester, PA | | | | | | | | | |
| Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is mainjury or other traumatic er | 1 | 21. Sunature of Funeral Service Licensee 22. Name and Address of Facility Hi | cks Hom | e for Fun | erals, P.A. | | | | | | | | | |
| | 1 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interv | | | | | | | | | | | | |
| Physician | | failure. List only one cause on each line. | | | Between Onset and Death | | | | | | | | | |
| Examiner | Immediate Cause (Final disease or condition resulting in death) a. Methadone, Oxycodone and Alprazolam Intoxication Due to (or as a consequence of): | | | | | | | | | | | | | |
| | . | Sequentially list conditions, b. | | | | | | | | | | | | |
| | Ē | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | | | | | | | | | | | |
| ed 1sit | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | |
| 3760, ficate be executed g physician and s the burial - transit | | MENDED ☐ AMENDED23a,27,28a-f,per me,g929 7-30-1 | 2 sm | | | | | | | | | | | |
| 8760, ifficate be ng physici | | IF FEMALE: 23c. If yes, outcome of pregnancy | | 23d. Date of deli | very | | | | | | | | | |
| Sox 687 leath certific e attending p | jan/ | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific) | ancy | Month | Day Year | | | | | | | | | |
| Box 68 e death certi the attendin | ysic | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | | | | | | | | | | | | |
| P.O. B is that the d gned by the e detached | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | to the cause of death? | | | | | | | | | |
| s, P.C iires that signed d be dete | ed by | | | | Probably 4 Unknown | | | | | | | | | |
| ords, w requires as been as be | Completed | | 24a. Was autop | sy prior | e autopsy findings available to completion of cause of | | | | | | | | | |
| Zec The la cate h | E | | perfor 1 ✓ Yes | | | | | | | | | | | |
| tal Recian: The certificate ector, page | Be | 25. Was case referred to medical examiner? [Hospital: 4 Inspiral: 3 Inspiral: 4 Inspiral: 4 | | Residence 6 🗸 0 | | | | | | | | | | |
| n of Vital Recing Physician: The After this certificate Inneral director, page | 의 | 1 Yes 2 No Position 1 Inpatient 2 ER/Outpatient 3 DOA Normal 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | | now injury occurred | trier. Scerie | | | | | | | | | |
| Division of Vital Records, tal or Atteoding Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the state of the sta | Certification: | Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No | subject | ingested | medications | | | | | | | | | |
| Visior or Attend ter death irrector: | lica | 2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. | 28f. Location (S | Street and Number or | Rural Route Number, City | | | | | | | | | |
| 3 Suicide 6 Could not be determined (Specify) Residence (Specify) | | | | | | | | | | | | | | |
| 1 7 元 三 | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a | | | | | | | | | | | | |
| To the within To the comple | Medical | and manner stated. 29b. Signature and title of certifier 29c. License number | | 29d. Date signed (| | | | | | | | | | |
| */ | - | O.C.M.E. | | June 23, 2012 | | | | | | | | | | |
| D | - | 30. Name and address of person who completed cause of death (Item 23a) | | <u> </u> | | | | | | | | | | |
| | | Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltin | nore, MD 21 | 223 | | | | | | | | | | |
| Sta Regist | ate | 31. Date filed (Month, Day, Year) 72. Registrar's Signature 6. Saules | | | | | | | | | | | | |
| i vegist | الته | TRAL I C MOTH DECORATE P. P. | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

| redrick William N | 1 | I- For State | | | nd / Depa | artment o | of Hea | alth and | | | ene | 2 | 01 | 2 2203 | |
|--|---|--|------------------------------------|---------------------------|--------------------|---|----------------------|------------------------|-------------------------------|-----------|--|--------------------------------------|-----------|--|--|
| Physiciar Medical Examin | 1/ | Registrar 1. Decedent's Name (First, M Frederick | liddle,Last) Willi | am Me | etz Jr | | | | | М | ate of Deal | Day Yea | ar | 3. Time of Death 1037 hrs | |
| | | 4a. Facility Name (if not insti 24406 Beeman Ro | | eet and num | ber) | | 4b. City, Bart | | Location of De | | ily 4, 20 | 4c. County Allegany | | | |
| Funeral Director | | 5. Social Security Number 216–86–4338 | 6. Sex | | Age (In yrs. | last birthday) Yr | Mont | der 1 Year ths Days | | | | th(MM/DD/YYY) 3/1970 | | hplace (State or n Maryland untry) | |
| Maryiand 28a-f show any d at once. | ا ق | Usual Residence of Deceder 10a. State 10b. Cou MD Ga 10e. Street and Number | | | | , Town or Loca arton | | ip Code | | | 10 | 0g. Citizen of Wi | nat Cour | 10d, Inside City Limits 1 Yes 2 No | |
| i with the Maryland ms 23a or 28a-f sho be notified at once. | - 1 | 137 Metz D | rive | . Was Dece | dent Ever in U | .S. 13. W | | 21521 dent of His | panic Origin? | Specify | Yes or No- | United 14. Race | | can Indian, Black, | |
| ter death ", or ite | by Funeral | | Divorced or I | Dates: | 2 X No | 1 | Yes, spec | cify Cuban, 2 🔀 No | Mexican, Pue | rto Ricar | n, etc.) | White Specify: | | | |
| imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours af ment of Health and Mental Hygene. taut: If item 27 is marked other than "natural or other traumatic event, the Wedden Examin | Completed | 15. Decedent's Education (Elementary/Secondary (0- 12 | | College (1-4 | | during r | | orking life. | DO NOT use | | ione | Constru | | • | |
| 21215-0036 Muld be filed within 7 Montal Hygiene. marked other than c event, the Medica | 8 | 17. Father's Name (First, Mic Frederi | ck Will | | etz Sr | | | | Eli | zabe | eth 1 | Maiden Surname Martin | | | |
| MD 21 d 2 should lith and Mer n 27 is man | | 19a. Informant's Name/Relat Frederick Me | | | | 169 | Metz | z Dri | ve, Bar | ton, | , Mar | iber, City or Tow yland 2 | 1521 | | |
| Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is in injury or other transition | | 20a. Method of Disposition 1 Burial 2 X Crema 4 Donation 5 Othe | Specify: | Removal from | State | Place of Dispo crematory or o mberlar | ther place and Ca | e) cemato | ory 07 | | /2012 | | lan | Town, State d Maryland | |
| Bal(permit Depart Importion) | | 21. Signature of Funeral Sen | 1 / | Sol | 7 | 11 | I1 Ch | nurch | St, We | ester | mpor | ral Home t, Mary | Land | 21562 | |
| Physician /Medical Examiner | | 23a. Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise or condition resulting in deat | use on each li ase a. Hy | ^{ne.} pertei | nsive A | Atheros | | | | | - | est, shock, or hea | | Approximate Interval Between Onset and Death | |
| | 1 | Sequentially list conditions, if any, leading to immediate | b | ` | onsequence o | | | | | | | | | | |
| ed nsit | Xamin | cause. Enter Underlying Car (Disease or injury that initiate events resulting in death) La | d c | | onsequence o | | | | | | | | | | |
| execut an and al - tra | © | | | | | | | | | | | | | | |
| lox 68760 leath certificate be a attending physicate for use as the bu | 2 | FFEMALE: 3b. Was decedent pregnant past 12 months? 1 Yes 2 No 9 | | Live birti | t at time of de | 2 Fe | etal death | _ | Ectopic preg | inancy | | 23d. Date of Month | | ay Y ear | |
| P.O. E res that the d signed by the | 2 | Part II. Other significant cor | ditions con | tributing to d | eath but not r | esulting in the | underlyin | g cause gi | ve n in Part I. | 2 | | | | ne cause of death? | |
| tal Records, ciao: The law require certificate has been si ector, page 2 should be a complete that the | Completed | | | | | | | | | - 1 | 24a. Was a autops perform Yes 2 | sy p m <u>ed</u> ? d | | opsy findings available ompletion of cause of S 2 No | |
| Vital oysiciao: | | 25. Was case referred to med examiner? 1 ✓ Yes 2 No | Hospi | tal: 1 Inp | atient 2 | ER/Outpatien | | | of Death (Cheo Other 4 Nur | sing Hon | | Residence 6 | Other: | Scene | |
| Division of Vital nation Attending Physiciao rea for death. al Director: After this cert led in by the funeral director. | | | ending vestigation | 28a. Date of (Month, D | Injury ay,Year) | 28b. Time of | Injury | | at Work? | 28d. | Describe h | ow injury occurre | ed | | |
| Division o To the Hospital or Attending with 24 hours after death. To the Funeral Director: Aft completely filled in by the fune | SILLE SI SILLE SILLE SILLE SILLE SILLE SILLE SILLE SILLE SILLE SILLE SIL | 3 Suicide 6 0 | ould not be etermined | 28e. Place o | f Injury - At ho | ome, farm, stre | et, factor | y, office bu | ilding, etc. | | ocation (S or Town, St | | er or Run | al Route Number, City | |
| Div To the Hospital or within 24 hours afte To the Funeral Dic completely filled in | | | xaminer:On t | | examination a | | | | | | | e(s) and manner and place, and de | | | |
| | 2 | 29b. Signature and title of cer figure of Mary | tifier lad. M | 21) | | | 29 | O.C.iv | | | | 29d. Date signed July 5, 2012 | · · | th, Day, Year) | |
| | -3 | 30. Name and address of per Pamela E. Southall | | | , | 23a) miner 90 | 0 W. Ba | altimore | Street, Ba | ltimore | , MD 21 | 223 | | | |
| Stat Registra | | 31. Date filed (Month, Day, Ye | 0 2012 | | strar's Signatu | be | res |) | | | | - | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Benjamin H. Markline 09:45PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Genesis Multimedical Center To WSON 5. Social Security Number 6. Sex 1 **M** M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Maryland Months Min. 9/12/ 1932 5-34-6764 79 Director Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. trnent of Health and Mental Hygiene. trant if I fear 22 is marked outber than "natural", or items 23a or 28a-f show jury or orher traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Tes 2 No Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3955 Madonna Road 21084 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. à 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Mick Markline Edith Roberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 (Dau. 3953 Madonna Road Karen K. Duhala Jarrettsville, MD. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 5. permit. Page 1 Department of Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 2012 Madonna, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home. P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Acute on Chronic Renal Failure (Stage thre Chronic Kidney disese) 3-4 weeks Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Left Hydronephrosis within 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Berugn Prostatic Hypertroph Due to for as a consequence of: Cause (Disease or iinjury vears that initiated events resulting in death) Last Be Completed by Physician/Medical Recurrent winary tractinfections oast 6 months Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Peripheral Vasular Disease 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Hypertension cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemie 24a. Was an performed? Yes 2 No Parkinson's Disease with Dementia To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 I Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Michellet. Kalender CRNP R097104 July 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Michelle E. Kalendek CRUP Genesis Multimedical Center 7700 York Road Towson, MD 21204

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Donald R. Oswald 2012 5:30a^M Medical June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 2600 Oswald Drive Hampstead Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours 217-24-2763 **Director** 1 X M 2 D F 81 11/30/1930 Usual Residence of Decedent 28a-f show 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director notified Carroll MD Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 2600 Oswald Drive 21074 USA or items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 105 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 rr Yes, Give Year or Dates 1951-54 1 Tes 2 No Specify. white Specify "natural", 3 Widowed 4 Divorced ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Bethlehem Steel steelworker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and L.

Jf Health and In.

If item 27 is marked to "short traumatic evil. marked ပ Eva Fowler Robert Oswald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Oswald Drive, Hampstead, MD 21074 Palma Oswald, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of h Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/19/2012|Hampstead, MD Carroll Cremation Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Trand 934 S. Main St., Hampstead, MD 21074 Lem 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Pregnant at time of death 5 Other (specify) Dav Year ed by the a 1 Yes 2 D g 🗌 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Nuknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 X No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D15552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 826 Washington Rd Ste #204 Westminster, md 21157 Jajont 2 M. D . Date filed (Month, Day, Year) JUN 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:55 A M Owsianny June 22, 2012 Arthur Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Hospice House Prince Frederick Calvert. 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 09/23/1923 396-16-9349 Director Wisconsin Usual Residence of Decedent 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes 2 X No Maryland 1 4 1 Calvert St. Leonard 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 4029 Lloyd Bowen Road 20685 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3

Widowed 4 □ Divorced Specify: White "natural" Completed h and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Design Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Owsianny Frances Baranowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Wilhelmina Winstead / Companion 4029 Lloyd Bowen Road, St. Leonard, Maryland 20685 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 06/25/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee Rausch Funeral Home, PA 22. Name and Address of Facility ▶ Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year detached the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 🗌 No 1 🗌 Yes **Division of Vital** filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending Accident
Suicide
Homicide 1 Yes 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D45092 Parul Sanatkumar ause of death (Item 23a) (Type, Print)

Registrar

State

JUN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND PI LINE A State of Maryland Poppartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Month Jean M. Owens June 16, 1400 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 1400 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Min June is, 2017 Director 579-42-5598 1 M 2 XF Usual Residence of Decedent 81 Sept. 22, 1930 DC 28a-f shov 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral with items 23a 18606 Walker's Choice Road #4 20886 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: Black 'natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Radiologic Technician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ralston Mathews Lucy Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 18606 Walker's Choice Road # 4 Gaithersburg, MD Edana Golding - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Clinton, Maryland 21. Signature of Funeral Service Licensee any in once. 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewart 20019 M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SEVERE BLOOD LOSS Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical GASTROINTESTINAL BLEEDING Due to (or as a consequence of): **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACUTE RENAL FAILURE 1 ☐ Yes 2 📜 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 Impatient 3 Impa After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation filled in by the I 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068080 06/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Siversha Jalli, MO 9901 Medical Center Drive, Roderille, Maylad 20850 Sireesha Jalli, Mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Lest) July 2, 2012 **Physician** 0215 Alexander Benhardt Ober, Jr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner Westminster
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Yeer) Westminster Ridge Assisted Living
Social Security Number 6. Sex 7. Age (In yrs. last birti Carroll If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1⊠M 2□ F Nov 24, 1921 Pennsylvania Director 90 177-18**-**8978 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural; or Items 23a or 28a-f ehow any Injury or other traumetic avant, the Medical Evarriner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Westminster MD Carroll 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number USA Apt. 12B 21157 507 High Acre Dr. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1943 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 2 🗆 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: ģ White 3 Widowed 4 □ Divorced 1946 Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Data Processor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Pretting Alexander B. Ober, Sr. ဥ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, MD 21158 247 Bell Rd. Alex G. Ober/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/5/12 Hampstead, MD Carroll Cremation, Inc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Westminster, Maryland21157 412 Washington Rd. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Mnorexia /Medical **Examiner** Due to (or es a consequence of) months Examiner ementia been signed by the attending physiclan end should be deteched for use as the buriel-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Lest 23b. Did tobscco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 pertension Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? Hyperlipidemia 24a. Wes en autopsy performed? 8 pace 2 The 1 🗆 Yes 2 3 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 1 → Yes 2 No 3□ DOA Certification: To efter deeth. Director: After this 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Yeer) 27. Menner of Deeth 5 Pending investigation 1 Anatural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide To the Hospital or within 24 hours er To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO051924 0 ho completed cause of deeth (Item 23a) (Type, Print) In MD2973 Manchester Rd Manchester MD 21102 Henderson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Xue Mei Pan 2012 7:46 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 216-63-4061 **Director** 83 1 M 2 XF Aug. 1,1928 China Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4521 East West Highway #1010 20814 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ö Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural" Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Ball Bearing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Min Bent (Daughter) 407 Fifth Avenue, Washington Grove, MD 20880 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory June 22, 20c. Location - City or Town, State Page 1 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Alexandria, VA Signature of Funeral Service Licen e 22. Name and Address of Facility
DeVol Funeral Home, 10 F
Gaithersburg, 10 East Deer Park Drive, urg, MD 20877 Firt 1. Enter this disease, or complications that caused hock, or heart ailure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Imm diate Cause Inal disea or cond on Onset and Death Physician baracr Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence on Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by AN XUEME! W 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 nas autopsy Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death

To the Funeral Director, A

Completely filled in by the f Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tracey Pyles M.D., 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, 25 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PM 11:15 **Physician** William Palmel 2012 26 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Min **Funeral** Days Hours 1**X**□M 2□F 101 3/10/1911 WEST VIRGINIA 234-01-6822 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner minet because once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No BALTIMORE BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2421 MATTHAI TERRACE 21219 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ¥☐ No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SHIPYARD WELDER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET BOYER WILLIAM PALMER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7104 RIVER DRIVE ROAD, BALTIMORE, MD 21219 PEGGY WARLICK/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition JUNE 30. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEDGESVILLE CEMETERY 2012 HEDGESVILLE, WV 22. Name and Address of Facility Harman Funeral Servic 21. Signature of Funeral Service Licensee 7221 Grayburn Dr Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asystole Physician disease or condition resulting in death) //Medical Due to (or as a consequence of): 5 hours Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a contenue of) or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical use as 1 attending IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death Ectopic pregnancy Day Year for in the past 12 months? Month 5 Other (specify) Pregnant at time of death ☐ Yes 2☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform bage : 1 Yes 2 No 2 14 No 26. Place of Death Check on one 25. Was case referred to medical examiner? director. Be Hospital: 1 The patient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 5 Residence 2 After this 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fur

State Registrar

Medical

(check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed, MD Haitham

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

June 26, 2012

22. Registrar's Signature 31. Date filed (Month, Day, Year) 1 2 2012

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 Day 2012 Year JUNE CHARLES PARK. 8:40 ам FRANCIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Cecil Earleville 24 Gunpowder Dr. Social Security Number 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Aug 19 1953 Months Director 201-44-1092 58 Pennsylvania Usual Residence of Decedent if the TS is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No New Castle Newark 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 581 Oakdale Rd. 19713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc Armed Forces ☐ Yes 2 🛛 No 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes, Give Specify 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair Shop Auto Mechanic 10 Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) Elizabeth Maude Green Francis Charles Park, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) West Grove, PA. 19390 James J. Park (son) 216 Little Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 Removal from State 4 Donation 5 Other (Spe Kent Cremation Services 6/11/12 Smyrna, DE. ²². Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 Approximate Interval Betw . Enter th disease, or complications that caused the death failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear Immediate Cause (Final Physician/ disease or titi resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a-To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the bunal-tran and that initiated events Due to (or as a resulting in death) Last signed by the attending physician be detached for use as the bunal Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe 2 🗆 No 1 🗌 Yes certificate Yes 2 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA this 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License numbe 29b. Signature and title of certifie

State Registrar 30. Name and addr

31. Date filed (Month

who completed duse of death (Item 23a) (Type, Print)

32. Registrar's Signature

73628

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June HARRIE ELIZABETH PYLE 7:25 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1304 Worth Bend Road Jarrettsville Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 94 Director 214-30-7144 ^{ខ្មែ}ា Maryland Usual Residence of Decedent and Mental Hygiene.

'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Mediral Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 Yes 2 X No MD. Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 North Bend Road 21084 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Murse Mursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burton injury or other traumatic Mary (unknown) permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 1304 North Bend Rd. Jarrettsville, MD. Charles E. Pyle (Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July at 6. 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Air Mem. Gardens 2012 Bel Air, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral anyi Home. Jarrettsville, Maryland P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCIEROTIC CARDIOVACULADOISTAKE Immediate Cause (Final Onset and Death Physician/ Medical disease or condition resulting in death) Examiner MULTI INFARCT DEHENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ULCERS, HEEL TERHINAL physician and the bunal-transit DECUBITUS or Attending Physician: The law requires that the death certificate be executed that initiated events Due to or as a consequence of):

PROJETN MALNUTRITION, TERMINH resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ģ Pregnant at time of death Month Yes the a g Unknown hed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be d 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 2 No 1 Yes 2 No ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation the within 24 hours after deat To the Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier NL42, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PERFECTO C. VHARAD, N.D., i 1716 HARFORD RASU, 105 PAUSTON MO21047 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per verbal G929 7/23/12 dk
State of Maryland / Department of Health and Mental Hygiene for State Registrar 22041 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDWARD HERMAN REIHL JUNE 24, 2012 8:45 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN NURSING & REHABILITATION CHESTERTOWN 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months 04/03/1921 MARYLAND Director 219-07-6817 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 1 Yes 2X No **KENT** ROCK HALL MD 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be items 23a Funeral 5310 SKINNERS NECK ROAD 21661 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MASTER PLUMBER/ELECTRICIAN 12 PLUMBING/ELECTRIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WALTER REIHL IDA MERCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 MEADOWVIEW DRIVE CHESTERTOWN, MARYLAND 21620 CECIL UNRUH / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL CEM. 06/28/2012 ROCK HALL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUENRAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between 20 Onset and Death Immediate Cause (Final SEPS IS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as Bladder Empt UON and I-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No ed by the a detached f Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Hospital or Attending Physician; The Yes 2X No 25. Was case referred typedical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending injury within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. arginer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec. only one) Certifyin se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 9b. Signature a nd title of cert 29d. Date signed (Month, Day, Year) GI Name and address of person who completed cause of death (Item 23a) (Type, Print) MO190 State JUN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JUDITH ADRIENNE ROSENTEL 06 20 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO SAUSBU14 Peninsula If Under 1 Year If Under 24 Hrs Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Director 196-34-2339 1 M 2 F 68 02/13/1944 Pennsylvania 10d. Inside City Limits er than "netural", or items 23a or 28e-f sho 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No DE Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23604 Dove Road 19973 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 x No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tent: If item 27 is marked other tha ury or other treumatic event, If we have <u>Para Mutual Ticket Seller</u> Gambling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adrian Joseph McCarr Frances Rhines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne L Mellin / companion 23604 Dove Rd, Seaford, DE 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odd Fellows Cem 06/26/2012 Seaford, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 13 E Grove St, Delmar, DE 19940 23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ MULITRE SYSTEM ORGAN VECT Medical resulting in death) Due to (or as a consequence of): Examiner WTURFO OLODENA Sequentially list conditions, je if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events M-TOR VAUE LEPAR Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) |2 1 Tes 2 🙀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending iniun work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2012 JUNE 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ralph E. Riley June 2012 11:10 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons 5 Calvert **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign PA Country) Hours Min. 1 💢 M 2 🗆 F 0170171924 **Director** Yrs. 195-22-3843 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FLSt. Lucie Port St. Lucie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34952-6350 United States 22 Lake Vista Trail, Apt. 204 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 □ No If Yes, Give 1941–1945 Year or Dates. Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker Sheet Metal Local 100 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental ည Samuel Ellis Riley Bertha Mae Yingling injury or other traumatic and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 Health tem 27 Ralph Owen Riley - Son P. O. Box 753, Solomons, Maryland 20688 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Metropolitan Crematory 6/23/12 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Lice Rausch Funeral Home, P. A. 22. Name and Address of Facility P. 0. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Viela-S disease or condition Medical resulting in death) **Examiner** cell. mmers Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No 124 hours after death. • Funeral Director: A pleted filled in by the fi death. Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D

Registrar

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31. Date filed (Month, Day, Year)

JUN 25 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

Anwar Munshi, MD 130 Hospital Road, Suite 300, Prince Frederick, Maryland 20678

1)0019427

June 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gertrud Rose 2012 :50 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9318 Sea Oat Court Calvert North Beach Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 6/2/1923 89 028-34-8997 Germany Director Usual Residence of Decedent 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits notified at Director 28a-f MD Calvert 1 X Yes 2 No North Beach 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ems 23a or r must be r Funeral 9318 Sea Oat Court 20714 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Importants If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Johann Viehmann Katharina Porr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid Falanga/Daughter 9318 Sea Oat Ct., North Beach, MD 20714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/12 Beltsville, MD Chesapeake Crem. 21. Signature of Funeral Service icenses 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CORDNARY ARTERY Physician DISERSE EARS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant : been signed by the should be detached 1 Li Yes 2 L Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 certificate 2 🗌 No 1 Yes Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi မ

KW 10

30. Name and address of person with com 31. Date filed (Month, Day, Year) State Registrar

UDGE 32. Registrąr's Signature

5

completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Julia AM 10:12 7017 Medical Tone 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Health Institutes Bethesolo Montaomer I If Under 24 Hrs. (9 Birthplace State or Foreign Country) Mayaguez Puerto Rico Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 574-88-9227 1 □ M 2 ⋤ F Months Days Hours Min 1 (Month 7 Day 198)1 30 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified PHILADELPHIA PA Philadelphia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 528 GERRITT STREET 19147 IIS within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black, White, etc. ō þ 1 XNever Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give 1 X Yes 2 □ No Specify: PUERTO RICAN "natural" Completed 3 Widowed 4 Divorced Hispanic Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Financial Aid if Health and Mental Hygi item 27 is marked othe other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Jorge H. Rodriguez Elizabeth Morales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1895 North Tamiami Trail, Unit #C10, FL, 33903 19a. Informant's Name/Relationship (Type, Print) Jety N. Jety N. Jety N. Jety N. Jety N. Jety Page 1 and 2 sho Department of Health Important: If it is any init. Meyers Elizabeth Rodriguez/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Nest Laurel Hill Crematory 1 Burial 2 X Cremation 3 Removal from State Bala Cynwyd PA 6-22-2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner weeks Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit months Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death n signed by the a ld be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? The law has autopsy performed 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tity 29d. Date signed (Month, Day, Year) MQ 153941 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

2012

Baltimore, Maryland 21215-0036

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P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBINSON SPENCER **JAMES** 2012 JUNE 10, 6:38 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Suitland George's 2205 Houston St. If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 📉 M 2 🗆 F Months Hours 577-58-0049 65 13.46 **Director** WashingtonDC Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County Director 1X Yes 2 ☐ No Millersville Anne Arundel MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21108 557 Lanny Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give VIETNAM— Year or Dates—EKA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pvt Industry Supervisor 12±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvia Foulks James Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Robins**o**n 2205 Houston Street Suitland, Maryland20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 2012 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cheltenham Vet CemJune 15, Cheltenham Maryland 21. Signature of Fineral Service Lic 22. Name and Address of Facility NE, Washington, DC 20019 Tyrone J. Young Fun Ser. 5635 Eads Street Part 1. Piter the disease, or complication of heart failure. List only one ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death s that caused the Immediate Cause (Final disease or condition CARDIO-RESPIRATORY ARREST Medical resulting in death) Due to (or as a consequence of): Examiner **ESSENTIAL HYPERTENSION** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or): DIABETES MELLITUS TYPE II Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 D Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown ALCOHOL ABUSE History Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TOBACCO USE autopsy has 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 🗌 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA J ☐ Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: X Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

NAVJIT KAUR GORAYA, M.D., VAMC, 50 IRVING STRETT NW, WASHINGTON, DC 20422/688 32. Registrar's signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

#D58171

JUNE 12, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Terry Alan Renner 4:00 pM 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 1535 Crest View Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Director 219-66-0226 1 🕱 M 2 🗆 F 56 May 31, 1956 Maryland 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10h County must be notified at Director MD Hagerstown 1 Yes 2 X No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 by Funeral 23a 1535 Crest View Ave. 21740 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ed other than "natural", or iter event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Mo Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Distribution Center Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Betty Huff Earl Renner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1535 Crest View Ave., Hagerstown, MD Angela Thompson/ Daughter nt of Health : If item 2: or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Department o Important: If any injury or Smithsburg, MD Smithsburg Crematory 6/29/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Man 1601 Pennsylvania Ave., Hagerstown, MD 21742 r – Itions that caused the death. Do not enter the mode of pying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ည 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 20. Name and appress of person who completed cause of death (Item 23a) (Type, Print) 2916 Courance Dr. 12916 Courance Dr.

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Amend#17 per FH State of Maryland State of M22/2012 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Day 9:30 7012 JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 125 FARRAGUT ROAD ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Country Director 235-16-2524 1 X M 2 □ F 94 9/28/1917 MARTINSBURG WV permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL ANNAPOLIS 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 125 FARRAGUT ROAD UNITED STATES 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Year or Dates. 1941 3 X Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) 12 TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE L. RENCH RENTCH ROSA MCDANIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 FARRAGUT ROAD ANNAPOLIS, MD 21401 JOHN RENTCH/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State CHESAPEAKE CREMATION 6/22/2012 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD LASTING TRIBUTES BY FELLOWS NAM CREMATION & FUNERAL CARE D ANNAPOLIS, MD 21401 22. Name and Address of Facility
HELFENBEIN & NEW
814 BESTGATE ROA 21. Signature of uneral Service I cens 23a. Dath 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmenary Physician/ Chronic disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 ☐ Yes 2 No 1 Yes within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNO ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ASS, Sod Liv. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3167 Braverton 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Judy Ann Ravenscroft Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) September 30, 1939 218-38-2342 72 **Director** 1 🗆 M 2 🔀 F Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Frostburg Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 19300 Upper Paradise Street SW 21532 USA "natural", or item edical Examiner n Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White Completed 3 Divorced 4 Divorced Specify. Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Home 0 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ George Elmer Robertson Loretta May Fair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trat John Wilson Ravenscroft - Husband 19300 Upper Paradise Street SW, Frostburg, Maryland, 21532 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Cumberland Crematory Important: If any injury or once. July 04, 2012 Cumberland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Poset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Askiratur Physician/ Proumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year g Unknown g Unknown P.O. ĝ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 1 Tyes **Division of Vital** Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 100 Other: 1 Yes ၉ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? Hospital or Attending (Month, Day, Year) Natural Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D-70131 MIAG 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrook Road Combehand MD-21502 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J MME 2 8 gay 20^Y1^a2 6:45A M RUBLE CARL ROLAND Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLOTTE HALL ST. MARY'S CHARLOTTE HALL VETERANS HOME . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1X M 2 | F Days Hours DEC. 19 Year 1931 WEST **Director** 80 235-48-6619 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES LA PLATA 1 ₹ Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Ū. Funeral 103 MADISON STREET 20646 S. 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 □ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify:WHITE Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE OF REP. ELECTRONICS ENGINEER permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NELLIE FAY SIMMS CARL BURL RUBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $103\ \mathtt{MADISON}\ \mathtt{STREET}$, LA PLATA, MD 20646PHYLLIS A. RUBLE/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) JULYDate 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETS. CEMETERY 3, 2012 CHELTENHAM, MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service Licensee 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between APONO CARCINOM Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) the attending physician Physician/Medical that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 Yes 2 No 3 Probably 4 Unknown ARTSEL DISCASÓ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy 2 No 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of co ifier 29d. Date signed (Month, Dav. Year) H0037228MO TONG 28, 2012

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

22333 Greenview Pkwy Unit 5A Great Mills, MD, 20634

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Cafferty
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended#19b, 1= For 6/28/12, M.S. Kent Co.

Certificate of Docth

Certificate of Docth Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2205 201 naries Medical give street and number) 4c. County of Death 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death **Examiner** Baltimore Mary ical and Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 217-12-7753 1 **X**) M 2 \square F 08/18/1921 MARYLAND 90 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No MD KENT ROCK HALL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a Funeral UNITED STATES 5811 SOUTH HAWTHORNE AVENUE 21661 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 No Specify If Yes. Give 3 X Widowed 4 Divorced WHITE Completed Year or Dates. 1942-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) POLICE OFFICER LAW 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY JONES WILLIAM FRED STILL $^{19}_{L}$ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 s nt of Health a : If item 27 i SECOND AVENUE BETTERTON, MARYLAND 21610 LINDA MANCUSO / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) HAMPSTEAD CEMETERY 06/29/2012 HAMPSTEAD, MARYLAND Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, with A 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Right disease or condition Medical resulting in death) Due to (s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law regulres that the death certificate be P.O. Box 68760 as the l cate has been signed by the attending I page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Typertension autopsy perform death? 1 ☐ Yes 2 ☐ No After this certificate or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Hospital ျှ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No 5 Pending injury within 24 hours after death. To the Funeral Director; A Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rudinsk Meg

State Registrar 31. Date filed Wonth, [

egistrar'ş Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** nester River Kent Hospital Birthplace (State or Foreign Country) cial Security Number 7. Age (In yrs. last birthday) **Funeral** (Month. Day, Year) Hours Director 1 🗆 M 2 🗶 F 141-14-9340 **NEW JERSEY** 05/24/1922 90 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo CHESTERTOWN **OUEEN ANNE'S** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral UNITED STATES 105 COLEMAN DRIVE 21620 or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Year or Dates. 1945-46 WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) HEALTH CARE REGISTERED NURSE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ ANNA PAUL RICHARD DYKSTRA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 COLEMAN DRIVE CHESTERTOWN, MARYLAND 21620 JUDITH SISSON / DAUGHTER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ■ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LAUREL GROVE CEMETERY 06/26/2012 TOTOWA, NEW JERSEY Signature of Funeral Service Lice PELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 or combile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury 4 Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last been signed by the attending physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Fractures. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Wertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 only one) 29b. Signature and title of certifier Jale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Michael Wayne Simonds Physician/ 20<u>12</u> June 9, 1715 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min (Month, Day, Year) 56 579-74-5193 1 XM 2 □ F **Director** Jan 9, 1956 Washington DC Usual Residence of Dec 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 1 ☐ Yes 2 X No Spring Grove PA York 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral USA 17362 2 Lakeview Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, I 1 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white "natural", 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than "1 raumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Commercial 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lorraine King Robert Simonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 2 Lakeview Drive, Spring Grove, PA 17362 Beverly Simonds, wife permit. Page 1 and 2 Department of Healt Important: If item 23 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Smitry, grematory or other place 1 Burial 2 Cremation 3 Removal from State 6/12/2012 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory Myers-Durboraw Funeral Home 22. Name and Address of Facility Signature of Funeral Service Licenses 91 Willis Street, Westminster, MD 21157 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SIMBELLILB METASTATIC ADENOCATIONOMA Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, rany, teacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for de a contreguence of that the death certificate be executed and burial-trar Due to (or as a consequence of) ũ resulting in death) Last physician Physician/Medical Box 68760 the as IE EEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Ď in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the detached 9 Unknown 9 Unknown P.O. I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 E only one 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) D31660 Co/11/2012 Cle He My 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U. 295 STUMBER ACCEPTE WESTMIASTG! THOMAS MANULA LU MEZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

State

JUN 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Franklin Statum Elwood 2012 1800 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico isburg Salisbury Rehabilitation & Nursing Ctr 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Nu **Funeral** Min 1 🛣 M 2 🗆 F 07/05/1927 213-24-4721 84 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Salisbury Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21804 31109 Mt. Hermon Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Clerk Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Blanche Virginia Drake ပ Elwood William Statum 19a. Informant's Name/Relationship (Type, Print)

Lauren Martz/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5857 Cumberland Dr, Salisbury, MD 21804 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Unfity Washington 1 X Burial 2 Cremation 3 Removal from State 6/28/2012 Hurlock, MD 4 Donation 5 Other (Specify) Cemetery ure of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 monno Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau, or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Cere disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a sonsequents of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death page 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Unknown been signed by the 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျင 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 A Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and address of person who completed cause of death (Item 23a) (Type, Print) 200 chalas 31. Date filed (Month, Day, Year) . egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

25 2012

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>12</u> Herbert A. Stanwood III June 4:05 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5225 Pooks Hill Road Apt. 503 South Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 63 212-54-1010 10/19/1948 Tennessee Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5225 Pooks Hill Road Apt. 503 South 20814 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Designer/ Elementary/Secondary (0-12) College (1-4 or 5+) <u>Sales Representative</u>

18. Mother's Name (First, Middle, Maiden Surname)

South Stafford Street Arlington, VA 22201

20c. Location - City or Town, State

Falls Church, VA

Month

Day

24b. Were autopsy findings available prior to completion of cause of

death?

Year

Interval Between Onset and Death

Helen Berg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

06/20/2012

22. Name and Address of Facility Joseph Gawler's Sons LLC 5130 Wisconsin Ave. NW Washington, DC 20016

Baltimore, Maryland 21215-0036 permit. Page 1 a
Department of H
Important: If ite
any injury or ott Physician Medical

Examiner

and

by the attending physician

has

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

Hospital

State
Registrar

10a. State

Physician/

Medical

Examiner

Funeral

Director

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f Health aitem 27 i

the Medical

Director

Funeral

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Completed

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17. Father's Name (First, Middle, Last)

20a. Method of Disposition

21. Signature Funeral Servide

Herbert A. Stanwood Jr.

Thora Stanwood / Sister

1 Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

the Maryland

and 2 should be filed within 72 hours after death

1 use as the burial Physician/Medical þ Completed page 2 funeral director, Be ပ Certificate:

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final CMML Leukemia disease or condition resulting in death) Due to (or as a consequence of): Community Acquired Pneumonia Sequentially list conditions, Due to for as a nonsequence on cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown 2 No Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? __1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined

20b. Place of Disposition (Name of

National Crematory

within 24 hours after death.

To the Funeral Director; After this certificate has the following the City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Date signed (Month. Day, Year, 10 MD0052247 06/18/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Collin D. Cullen MD 7625 Wisconsin Avenue Suite 101 Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Day James Richard Smith 2012 June 21 10:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Months (Month, Day, Year) Hours Director 577-32-5887 1 X M 2 T F 83 Yrs. May 6, 1929 Washington, DC items 23a or 28a-f show ler must be notified at 10b. Count the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 10124 Pierce Drive 20901 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. ral", or iter Examiner 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: SpecifyWhite If Yes, Give "natural", Completed 3 - Widowed 4 - Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Architectural Engineer NIBS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George H. Smith Cecelia E. DelTufo and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Dolores Ann Smith/Wife 10124 Pierce Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or June 25 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD $201\bar{2}$ 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. E Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physicin Sepsis weeks Medical Due to (or as a consequence of): Examiner Pneumonia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician use as the bur Physician/Medical certificate be Box 68760 IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Dav Pregnant at time of death 2 No P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Coronary Artery Disease, Diabetes Mellitus 1 Yes 2 No 3 Probably 4 XUnknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page death? perforn Hospital or Attending Physician: The this certificate Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 XNo ပ 1 🗓 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifier 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) D32332 June 22, 2012 who completed cause of death (Item 23a) (Type, Print) #220
a, MD 9801 Georgia Avenue, Silver Spring, MD 20902 0. Name and address of person who compl Suresh K. Gupta, MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State | State | of Marylar | | | | | lental Hy | giene | 0.0 | 1.0 | 2001 | |
|--|--|--------------|---|---|---|-----------------------|------------------------------------|--|----------------------------|---------------------------------|-----------------------|--|---|----------------------|----------|
| | Registrar 1. Decedent's Name (First, Middle, Last) | | | | | | tificate of | Death | | Reg. No. 2 U | | | 12 | 220: | 2 5 |
| | Physicia | ian/ | | | | | | | | | Month Day Y | | ar . | 3. Time of Death | м |
| | Medic Examin | | Lorraine H. Sch 4a. Facility Name (if not institution, | 4b. City, Town, or Location of Death | | | | fune 21 2012 4c. County of Deat | | | 5:15 A | - | | | |
| | Examin | C1 | 9530 Brink Road | | | | Gait | Montgo | | | | rv | | | |
| 60 | Funeral | | | 6. Sex 7. Age (In yrs. last birthday) | | | | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | | | 8. Date of Birth 9. B | | | ce (State or Foreig | gn |
| | Director | | 578-22-8027 | 1 🗆 M 2 💢 F | | 88 Yrs. | WIGHTIS | 3 Figure | IVIIII. | | | | Country | Carolin | 2 |
| Pu | at at | 'n | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | ty, Town or Loc | ation | | | Jan. Z | 4, 19 | 24 50 | | d. Inside City Limit | |
| Aarvia | Ba-f s tiffied | Director | Maryland Montg | omerv | | Gaither | shurg | | | | | | | 1 🗌 Yes 2 🗶 N | No |
| the A | or 2 De no | ΙD | 10e. Street and Number | <u> </u> | | | 10f. Zip Code |) | | | 10g. Citiz | en of What | Countr | y? | |
| - with | nust | Funeral | 9530 Brink Road | | | | | 20882 | | | | nited | Sta | tes | |
| teap | r item | | 11. Marital Status | Armed Fo | edent Ever in U. orces? | S. 13. V | Vas Decedent of Yes, specify Cu | Hispanic C ban, Mexic | Origin? (Spe an, Puerto | cify Yes or No- Rican, etc.) | 1 | 4. Race - A Black, W | | | |
| oster. | al", o Exam | d by | 1 ☐ Never Married 2 ☐ Marri 3 ဳ Widowed 4 ☐ Divorced | ed 1 ☐ Yes If Yes, Giv Year or D | | 1 | ☐ Yes 2 🗶 I | No Specif | fy: | | s | pecify: | Wh | ite | |
| 0500-612 | natur Jical J | ompleted | 15. Decedent | t's Education | | | ent's Usual Occ | | | | 16b. Kin | d of Busine | ss/Indu | stry | |
| 1 7 ii | han " • Med | omp | (Specify only highes Elementary/Secondary (0-12) | College (1 | | life, DC | ind of work don NOT use retire | e auring mo ed) | ost of worki | ng | | | | | |
| | lygier ther t | Be C | 11 | 0 | | Bus | iness M | | | | | 111d1r | ng | | |
| yland Idbe filed | ntal F | To B | 17. Father's Name (First, Middle, La | , | | | | | | e (First, Middle | | urname) | | | |
| | mark matic | · | Robert H. Huf: | | | Annie Lee Ca | | | | | | | | - 17 | |
| Nation 1 | alth ar 27 is ir trau | - 2 | Barbara Lee Ka | | ighter | 111 | Brink | | | | | | | 30) | - " |
| je Jag | Department of Health and Mehital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1 X Burial 2 Cremation | | 20b. F | Place of Dispos | | - 1 | | Date | 1 | ation - City | | n, State | |
| Page | ment ant: I | | 4 Donation 5 Other (S) | | Otate | ** | eaven C | | 06/2 | 5/2012 | Silv | er Sp | rin | g, MD | |
| baltimore, | Depart Import any inj once. | | 21. Signature of Funeral Service Lie | censee | | | Name and Add | | | eVol Fu | | | | 7 | |
| | | | 220 Part 1 Enter the disease or | = // Whan | | | E. Dee | | | | | sburg, | | | \dashv |
| Di | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dehydration Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death Month | | | |
| | ysician/ Medical | H | | | | | | | | | | | | | |
| E | xaminer | | Stroke | | | | | | | 3 | | 3 | Months | | |
| 3 | | iner | Sequentially list conditions, in any, leading to immediate cause. Enter Underlying | denos cij. | | | | | | | | · · · · · | | | |
| cuted | transi | Examiner | Cause (Disease or injury that initiated events | C | e Leuke | | | | | | | | 6 | <u>Months</u> | |
| e exe | ician a | dical E | resulting in death) Last | Due to | (or as a consequent | uence orj: | | | | | | | | | |
| cate b | physician and the burial-transit | | | d | | | | | | | | | | | |
| certific | attending p | II/M | IF FEMALE: 23b. Was decedent pregnant | | tcome of pregna | | E | | | | 2 | 3d. Date of | delivery | | ļ |
| death c | e atte | sicia | in the past 12 months? 1 ☐ Yes 2 🛣 No | | Birth 2 L Feta | | Other (specify) | | | | | Month | D | ay Year | |
| t te | by th | Physician/M | 9 Unknown Part II. Other significant condition | | | udda - Ja dha u | -11 | -ii- D | - 1 | | | | | | |
| es tha | been signed by the s | | Osteoporosis | is contributing to t | aeath but not res | suiting in the ur | idenying cause | given in Par | rt I. | | _ | | | cause of death? | l |
| requir | should | etec | Myelodysplastic | . C | | | | | | 1 ☐ Yes 2 🔀 No 3 ☐ | | | | | |
| necords, The law require: | s has b | Completed by | | | | | | | | auto | psy | prior death | 24b. Were autopsy findings available prior to completion of cause of death? | | |
| . = | ificate or, pa | a | Hypertension, A 25. Was case referred to medical | Arthritis | 3 | | 26 | Place of De | eath (Check | | ormed? 2 📉 No | 1 🗆 ' | Yes 2 | □ No | - |
| ysician: | direct | To B | examiner? 1 🗌 Yes2 🔀 No | Hospital: | Inpatient 2 | ER/Qutpatien | Lo | | | me 5 X Resi | dence 6 | Other (Sp | ecify) | 221 - 1120 | Î |
| 2 g | ter thi | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date | | 28b. Time of injury | 28c. ln | | | 28d. Describe I | | | | | |
| vision of | tor: At the fu | iffica | 2 Accident Investigation of Could in | ation | | | M 1 | Yes 2 | | | | | | | |
| or At | Direct Direct In by | Certificate: | 4 Homicide determin | 28e. Place | e of Injury - At ho ing, etc. <i>(Specif</i> y | ome, farm, stre /) | et, factory, offic | e | | 28f. Location (City or Tox | | Number or i | Rural R | oute Number, | |
| To be the Hospital or Attending Physician: The law requires that the death certificate be executed to the Hospital or Attending Physician: The law requires that the death certificate be executed to the Hospital or Attending Physician: | within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page: | | 29a. Certifier 1 Certifying | Physician: To the b | pest of my know | ledge, death o | ccurred at the ti | me, date ar | nd place, ar | nd due to the c | ause(s) and | d manner as | stated | | |
| he Ho | in 24 I | Medical | | caminer: On the bas Nurse Practitioner | | | | | | | | | | | ated. |
| To th | - 1 | | 29b. Signature and title of certifier | ndkl | - N | as | 29c. Lice | nse number | | | 29d. Date | signed (Mo | nth, Da | y, Year) | |
| | 20 | | D. Shu | | , ,,,, | | D: | 27301 | | | June | 21, | 201 | 2 | |
| | | | 30. Name and address of person w | | | | | | | D 1 | | 100 0 | | 0 | |
| | Stat | | Douglas R. Shur 31. Date filed (Month Day, Year) | | | | | ery Av | venue | , Kockv | ııle, | MD 2 | :085 | U | \dashv |
| | Stat Registra | ir | 31. Date filed (Moj) Pay, Year 25 | 2012 | Registrar's Signa | 8. pa | Mad. | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 9:00 PM 2012 JUNE <u>James Henry Stubbings, Sr</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Reeder's Memorial Home Boonsboro 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** May 1. 1 X M 2 □ F District 10 fbia 579-40-0163 Director 81 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10c. City, Town or Location Director Maryland Washington County Hagerstown 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **Completed by Funeral** U.S.A. 21742 14151 Strite Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sheet Metal Worker Union Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Spiritery C Marie L. Ratte James Douglas Stubbings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14151 Strite Rd. Hagerstown, MD 21742 Madeleine T. Stubbings-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2-2012 Silver Spring, MD Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, a complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTENIS SCLEROTIC CARDIO VASCULAR Immediate Cause (Final Physician/ disease or condition resulting in death) 225 Medical Due to (or as a consequence of): DISENSE Examiner Sequentially list conditions, it any background in club cause. Enter Underlying Examine Due to lor as a consequence of The law requires that the death certificate be executed the burial-trans Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the at d be detached for 4 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PARICOVSOVIS DIABETRS MALLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed SLEEP APNEA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy のなならいてア performed? MORBID 1 ☐ Yes 2 ☐ No Yes 2 L 25. Was case referred to medical examiner? Hospital or Attending Physician: Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 Wo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

e Funeral Director: Afte bleted filled in by the fun Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hos To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ∐ 3 □

TW-6 State

Registrar

29b. Signature and title of certifier

DR. VASANT

120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTA

340

P gistrar's Signature

MILL

STREET

29c. License number

13019

29d. Date signed (Month, Day, Year)

HAGERSTOWN, MARYLAND 21940

JUNE 28,2012

301-739-7100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 | 2

| | | | Fol | epartment of Health and N Ce <i>rtificate of Death</i> | | 2012 22061 | | | |
|----------------------------------|---|------------------|--|---|-------------------------------------|--|--|--|--|
| | DI | | Decedent's Name (First, Middle, Last) | or an oato or boats. | Reg. 2. Date of Death | 3. Time of Death | | | |
| | Physicia Medio | | Phillip Nathaniel Stallings | 4b. City, Town, or Location of Death | | | | | |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) 1950 Rochell Ave., #321 | | 4c. County of Death Prince George's | | | | |
| | Funeral | | 1 M 2 T F | r 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs | | | | | |
| | Director | | Usual Residence of Decedent | 5. | (Month, Day, Yea Sept. 6, | 9. Birthplace (State or Foreign Country) DC | | | |
| | iryland I-f sho ied at | ctor | 10a. State 10b. County 10c. City, Town o MD Prince George's Distriction | r Location Ct Heights | | 10d. Inside City Limits 1 ☐ Yes 2 X No | | | |
| | the Ma or 28a e notif | Dire | 10e. Street and Number | 10f. Zip Code | 10g. | Citizen of What Country? | | | |
| | th with ns 23a must b | Funeral Director | 1950 Rochell Ave., #321 | 20747 | | USA | | | |
| 036 | ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at | Completed by Fu | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates 1973—1975 | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☑ No Specify: | cify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 2-0 | 2 hour "natur edical | plete | 15. Decedent's Education 16a. De (Specify only highest grade completed) (G | ecedent's Usual Occupation live kind of work done during most of worki | ng 16b | b. Kind of Business Industry | | | |
| 7121 | vithin 7 liene. rr than the Ma | | Elementary/Seconday (U-12) College (1-4 or 5+) | e. DO NOT use retired) Comer Service | ט | S Government | | | |
| Maryland 21215-0036 | e filed value of tal Hyge of othe event, | To Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | (First, Middle, Maide | | | | |
| <u> </u> | should be file n and Mental I 7 is marked c raumatic eve | | Charles Bailey Stallings 19a. Informant's Name/Relationship (Type, Print) 19b. Name/Relationship (Type, Print) | failing Address (Street and Number or Rura | en Haskin | | | | |
| | $\alpha \pm \alpha =$ | 1 | Katrina S. Henderson - sister 195 | - | | | | | |
| ore | | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, | crematory or other place) | | c. Location - City or Town, State | | | |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | 4 ☐ Donation 5 ☐ Other (Specify) Cheltenh 21. Signatur of Funeral Service Licensee // | am Veterans Cem. 6/26/ 22. Name and Address of Facility T | | meltenham, MD | | | |
| ñ | Dep land | 13 | > Gudith K Johnsu | 6503 Old Branch Ave | | Hills, MD 20748 | | | |
| 1 | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dying, such as cardiac of | r respiratory arrest, | Approximate Interval Between Onset and Death | | | |
| | h, sician/ Medical | 8 (1) | disease or condition resulting in death) a. Due to (or as a consequence of): | lerotic cardiovasc | 0104 Q(S | tuse years | | | |
| | Éxaminer | er | Securification of the security is any, leading to immediate Due to (or as a consequence of): | | | | | | |
| | uted d ansit | Examiner | Cause. Chisease or injury that initiated events C. | | | | | | |
| | cate be executed physician and the burial-transit | alEX | resulting in death) Last | | | | | | |
| ×/60 | | Aedical | d | | | | | | |
| Box 68 | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as | Physician/M | 1 Yes 2 No 4 Pregnant at time of death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year | | | |
| 5 | at the c d by the letache | Phys | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in ti | he underlying cause given in Part I. | 23e Did tobacc | co use contribute to the cause of death? | | | |
| S, | uires th n signe ıld be c | ed by | | | | 2 No 3 Probably 4 Unknown | | | |
| Records, | aw reg as bee 2 shou | Completed | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of | | | |
| 9 | r: The l icate h r, page | | Of Was associated and an adjust | | performed 1 Yes 2 | | | | |
| or vital | ysiciar is certif directo | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa | 26. Place of Death (Check | | 6 ☐ Other (Specify) | | | |
| וסו | ling Ph | | 27. Man r of Death 28a. Date of injury 28b. Tim 1 Natural 5 □ Pending (Month, Day, Year) inju | e of 28c. Injury at york? | 28d. Describe how in | | | | |
| DIVISION | Attend r death ctor: / | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, | M 1 Yes 2 No | 28f. Location (Street | and Number or Rural Route Number, | | | |
| 2 | ital or urs afte ral Dire | | bullaing, etc. (Specify) | | City or Town, Sta | | | | |
| | e Hosp 124 hou e Fune | ledical | 29a. Certifier 1 Locatifying Physician: To the best of my knowledge, dead (Check 2 ☐ Medical Examiner: On the basis of examination and/or in only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowled. | vestigation, in my opinion, death occurred at | the time, date and pla | ace, and due to the cause(s) and manner stated. | | | |
| | | Σ | 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Day, Year) | | | |
| 3 Day tuffmanm 025001 06-27-2012 | | | | | | | | | |
| | 44 | | 30. Name and address of person who completed cause of death (Item 23a) (Type TAY LIPIMAN, M 9200 BASIL | - CT LARGO MC | 20774 | f | | | |
| ı | Stat | е | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ JA SM Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONTOOM TON MORIENTIST AKOMA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Maiyland Director 61 8 10d. Inside City Limits 28a-f show 10c. City, Town or Location ms 23a or 28a-f sho must be notified at State Funeral Director 1 🗆 Yes 2 No Ndover 10g. Citizen of What Country? 10f. Zip Code USA 20785 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. of Health and Mental Hygiene. If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married Completed by 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates BIACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Relations Specialist Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PROCTOR မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2c 7 7 0 19a. Informant's Name/Relationship (Type, Print) 5915 Department of Health a Important: If item 27 is any injury or other tra 0 Digon SON CHerry Wood 20b. Place of Disposition (Name of cemetery, crematory or other place)

Che SA PEAKE 20a. Method of Disposition 2/2012 Belto VIIIE, MD Wesled CHAUSS & Functions servace 1 🗌 Burial 2🐧 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mol Southern MD BIND DUNKINK, M. D 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MONKE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed N and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer iniury 5 Pending 1 Natural Accident Investigation Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011 32. Registrar's Signature

MKOMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 Day 3. Time of Death **Physician** 10:508M JUNE 2012 SAUNDERS GLENDA FAYE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wheaton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Dec. | 20, 1 Wheaton Manor Care Wheaton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕏 F Yrs. NC 63 Director 578-64-1880 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ir then "naturel", or iteme 23a or 28a-f ehow Ite Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD Prince Georges Brentwood 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 20722 USA 3902 Quincy St. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturer, or item any injury or other traumatic event, IL. Mental CORC. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: δ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk/Bus Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elijah Pelham Beulah Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, MD. 20708 Cherlyn Abbott - Daughter 8404 Montpelier Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 6-26-2012 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Superal Service Licensee 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland Victorial 4308 Suitland Rd. Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** FOILLING /Medical Due to or as a consequence of) Examiner Syrasanca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit () The law requires that the death certificate be executed Metastatic Carcunold resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 10m Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) After the funeral of 28d. Describe how injury occurred 27. Marner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35421 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 East Jefferson St. 3W Rockville, MD 20852 Angela L. Corbin, MD 32. Begistrar' Signature 31. Date filed (Month, Day, Year) State JUN 2 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHORT Physician/ Month M . ELVA 19:00 M 2012 July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 222-18-2787 Director 82 1 M 2 X F 9-4-1929 DELAWARE Usual Residence of Decedent 28a-f show aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified SUSSEX 1 🗌 Yes 2 🔀 No LEWES 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 30066 FISHER 19958 ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 0 1 Never Married 2 Married ☐ Yes 2 No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", WHITE Completed 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NWO HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H of Health and Mental H fitem 27 is marked ot 57 PT 12012 ပ MARVEL THEODORE В. ETHEL VEASEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERNON C. SHORT 19690 HOPKINS RD., LEWES, DE 19958 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGES CEM. 7/13/2012 HARBESON, DE Signature of Funeral Service Licenses SHORT FUNERAL SERVICES Leag m. Show 416 FEDERAL MILTON, DE 19968 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 11929 Due to (or as a consequence of): Exami Cause (Disease or injurthat initiated events resulting in death) Last and -trar Due to (or as a consequence of): physician s the buria Physician/Medical 40160 Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month for 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2 No 3 Probably 4 Unknown should Completed 1 Yes 24b. Were autopsy findings available 24a. Was an has page 2 autonsy prior to completion of duse of death? is certificate h I director, page 1 Yes 2 No Division of Vital 25. Was case referred to predical B B 26. Place of Death (Check only one) Hospital: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending iniury work?
1 Yes 2 No Acciden
Suicide Accident Investigation To the Funeral Director: , completely filled in by the 6 Could not be Face Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a
To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of o 29c. License number 53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trea U Bayer MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Schrodel Joann Humberson July 2012 3:41A Medical 4a. Facility Name (if not institution, give street and number) County of Death
Frederick **Examiner** 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-38-9828 1 🗆 M 2 🎖 F **Director** 73 Maryland July 4, 1938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 XYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 210 East Church Street 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Public Schools School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George B. Humberson Lenore Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 East Church Street, Frederick, MD 21701 Charles S. Schrodel, husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery July 6, 2012 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Theral Service Licentee 22. NKeeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final Ph_sician/ ancer disease or condition JEATS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events for use as the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year ☐ Pregnant at time of death ☐ Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? certificate 1 Yes __ Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 🔀 Natural 5 Pending injury s after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 1 To the only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [™]3"til 1, 20°12 Shreve 1:23 AM M Patricia Hallie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death Examiner Cumberland 1426 Dogwood Court Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 235-30-2552 Jul 119 ay 1 922 1 □ M 2 🔀 F 89 Director or 28a-f show notified at 10a. State 10b. Coun 10c. City, Town or Location

Cumberland 10d. Inside City Limits death with the Maryland Director MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō t be p 10g. Citizen of What Country? ms 23a c Funeral 21502 USA 1426 Dogwood Court 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. 5 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after white "natural", 3 → Widowed 4 □ Divorced Specify: Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Ada Kimble 17. Father's Name (First, Middle, Last) ပ Scott G. White Informant's Name/Relationship (Type, Print) Barbara Herndon Mailing Address (Street and Number or Rural Route Number Gity or Town State, Zip Off 21502 daughter 20a. Method of Disposition

1 Degral 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/3/2012 Restlawn Memorial Gardens MD LaVale Donation 5 Other (Specify) of Funeral Se anature 22. Name a Scarpello Femieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_si_ian disease or condition resulting in death) MUMONAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death led by the at detached fi 2 No 9 Unknown 9 1 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à a DE GENERATIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfor トナアか 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Ves 2 XNo Other: |@ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ours after death. leral Director: Af filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to only one the cause(s) and manner as stated

5#

State Registrar 29b. Signature and title of certifier

Month, Day, Year) 32. Registrar's Signature

somaldson M.D.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 Seton

42054

29d. Date signed (Month, Day, Year)

Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 ROBERT LEO SAUER JULY 4 9:57 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Chestertown Nursing & Rehab Kent 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Year) n 12 1924 Hours **Director** 193-16-9898 1 X M 2 🗆 F 88 Jan. Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits be notified at Funeral Director 1 🗌 Yes 2 🔀 No MD Cecil Earleville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a54 New Jersey Ave. 21919 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Auto Manufacturer 12 Chassis Dept. Supervisor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Sauer Rose Klinges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (wife) Earleville, MD. 21919 54 New Jersey Ave. Florence Sauer Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Kent Cremation Services 7/5/12 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 M00510 white disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease andition resulting in death) Onset and Death Ph_sician/ tailure 10 Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the ; signed by t d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

124 hours after death E Funeral Director: A letely filled in by the f within 24 ho

To the Fune

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(Check

29b. Signatu

only one)

and title of certifier

John C. Arrabal, Jr., M.D. 223 High St. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) **JUL 1 2 2012** 32. Registrar's Signature 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jume 11, Da 2012 Year Physician/ 5:27 Mary Katherine Trump-Amoss PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Taneytown 37 George Street If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days OCT 23, Year) 1955 56 215-48-9140 Maryland Yrs. Director Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified Carroll Taneytown 1 Yes 2 No Maryland 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USÁ items 23a Funeral 21787 37 George Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married "natural", or within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Bookkeeper other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Dorothy Nelson Charles Trump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 George Street, Taneytown, MD 21787 John Amoss, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville UM Cem 6/15/2012 Taylorsville, MD 22. Name and Address of Facility Myers-Durboraw Funeral Ho 136 E Baltimore St, Taneytown, MD 21787 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MUDCZIDUM disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AD/monsy Duser 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 I DOA မ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After teted filled in by the funeral 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Duzluz 6-12-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHW true tour, mg 31. Date filed (Month, 32. Redistrar's Signature State JUN 13 arker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $20\overset{\text{\tiny fear}}{1}2$ Kenneth Twentey Roy June 3:50 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 24 Hrs. Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 220-18-2193 1 🛛 M 2 🗆 F 86 Feb. 9, 1926 Maryland 28a-f shov 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2X No Derwood <u>Maryland</u> Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17401 Bowie Mill Road 20855 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1944- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. and Mental Hygiene. 1 Never Married 2 K Married Completed by X Yes Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 1946 Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Twentey Leslie Roy Florence Grossnickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau Janet T. Gross/Daughter 1447 Bidwell Lane, Huntingtown, Maryland 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cem. 6/29/2012 Myersville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metastadic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trap that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown embol Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 MNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 21,2012 20148 25+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Ave Gaithers bura

Registrar

State

Steven Dolinsky

JUN 25 2012

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

63

7501, VUIX JUNE 19,2012 1029

| | | | Please | Type or Print in E | | | | | | | ible. | | | | | | |
|----------------------------|--|-------------------------------|---|--|---|--|---------------|---|--------------|---------------------------|--|--|---------------------------------------|---------------------|-------------------|---|--------------------|
| | | 1 | For State Registrar | State of Maryland | | artment of F tificate of L | | and Mental | | ne . _{No.} 20 | 112 | 22070 | | | | | |
| Ī | Physicia | 1/ | 1. Decedent's Name (First, Middle, Last YUK LUN TSOI |) | | | | 2. Date o Month June | | ^D 2012 | Year | 3. Time of Death 10:29 AM | | | | | |
| | Medic Examin | _ | | | | | | | | | ty of Death ntgomery | | | | | | |
| | Funeral Director | | 5. Social Security Number 530-60-8767 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 1 🕅 M 2 🗆 F 89 Yrs. 7. Age (In yrs. last birthday) 1 Months 1 Days 1 Hours 1 Houder 24 Hrs. 4 Months 1 Days 4 Hours 4 April 19,1923 | | | | | | | Cou | 9. Birthplace (State or Foreign Country) China | | | | | | |
| | Aaryland 8a-f show tified at | 윘 | 10a. State 10b. County Maryland Montgon | | Town or Loc | | | | | | | 10d. Inside City Limits 1X Yes 2 □ No | | | | | |
| | vith the N 23a or 2 st be no | | 10e. Street and Number 101 Odendhal Road | Apt.#514 | | 10f. Zip Code 208 | 77 | | | g. Citizen of V United | | | | | | | |
| 336 | filed within 72 hours after death with the Maryland fled within 72 hours after the Yigiene. All the Wedical Examiner must be notified at event, the Medical Examiner must be notified at | by | 11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. | 1 | Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🕅 No | an, Mexican | gin? (Specify Yes or , Puerto Rican, etc. | No- | | ck, White | ican Indian, , etc. : 1an | | | | | |
| Maryland 21215-0036 | 72 hours n "natur Aedical E | Completed | 15. Decedent's Ed (Specify only highest gra | lucation de co <i>mpleted)</i> | (Give | dent's Usual Occup kind of work done (O NOT use retired) | during most | of working | | 6b. Kind of B | | | | | | | |
| d 212 | ed within Hygiene. other tha | a) | Elementary/Secondary (0-12) 12 17. Father's Name (First. Middle, Last) | College (1-4 or 5+) | X-Ra | y Techni | | er's Name (First, Mi | | Medic | | are | | | | | |
| yland | uld be file I Mental I narked o natic eve | To | Thung Yick Tsoi | 0.11 | | Xue Lian Zeto Mailing Address (Street and Number or Rural Route Number) | | | | | Cadal | | | | | | |
| , Mar | nd 2 shou ealth and n 27 is n er traum | 107 | 19a. Informant's Name/Relationship (T) Siu Cheung Choi | (Son) | | Broken | Oak R | oad Boy | ds, | Mary1 | and | 20841 | | | | | |
| Baltimore, | permit. Page 1 and 2 should be filed will be bepartment of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. | | 20a. Method of Disposition 1 [X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif. | Removal from State | emetery, crer e of E | sition (Name of natory or other place Leaven Ce | m. | June 22, 2012 | | | Spr | ing, MD | | | | | |
| Balti | permit. Departr Importa any inji | | 21. Signature of Funeral Service Licens | (M0111 | | 2. Name and Address D | | yDeVol Fu ark Dr. | nera Gai | al Hom thersb | e urg, | MD 20877 | | | | | |
| | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final | | | | | | ry arrest | ., | | Approximate Interval Between Onset and Death | | | | | |
| | Medical Examiner | | disease or condition resulting in death) | a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Cardiomyopathy b. Due to (or as a consequence of): Bilateral Pneumonia | | | | | | | | | | | | | |
| | 7 ± | xaminer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | | | |
| | e executer | ш | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequ | | | | | | | | | | | | | |
| . Box 68760 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director, page 2 should be detached for use as the buriet mait completely filled in by the funeral director, page 2 should be detached for use as the buriet main. | ompleted by Physician/Medical | | Completed by Physician/Medic | ysician/Medic | nysician/Medio | hysician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | d | aldeath 3 | ☐ Ectopic pregnar☐ Other (specify) _ | псу | | | | ate of de | iivery Day Year |
| , P.O. | es that the signed by be deta | | | | Part II. Other significant conditions of Hypertension | ontributing to death but not res | ulting in the | underlying cause g | iven in Part | l. 23e. | | | | the cause of death? | | | |
| Division of Vital Records, | ne law require te has been s age 2 should | | | | ompleted | ompletec | | | | | | | Was an autopsy perform Yes 2 | ed? | prior to death? | topsy findings available completion of cause of | |
| /ital | sician: certifica lirector, | To Be (| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 🎇 Inpatient 2 □ | EB/Outpatie | 10+ | | ath <i>(Check only one</i> ursing Home 5 | | nce 6 🗆 Otl | her (Spec | cify) | | | | | |
| n of V | ding Phy h. After this funeral c | | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | of 28c. Inju | | 28d. Desc | | v injury occur | | | | | | | |
| ivisio | or Attendatter deat Director: | Certificate: | Certific | Certific | Certific | 2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined | | ome, farm, st | | | 28f. Loca | tion (Stre | eet and Numi State) | ber or Ru | ral Route Number, | | |
| | Hospita 24 hours Funeral etely fillec | Medical | Oheal O Madical Ever | sician: To the best of my know iner: On the basis of examinatio se Practitioner: To the best of | n and/or inve | stigation in my opir | nion death o | occurred at the time. | date and | place, and d | ue to the | cause(s) and manner stateu. | | | | | |
| • | To the within To the comple | Σ | only one) 3 L Certifying Nur 29b. Signature and title of certifier | se Practitioner. To the best of the | my knowledg | | se number | are princey and | 29 | June 2 | ed (Mont | h, Day, Year) | | | | | |
| | | | 30. Name and address of person who Dr. Kimberly Zuz | | n 23a) (Type, 500 01 | Print) d George | town F | Road Bet | hesd | la, MD | 208 | 14 | | | | | |
| | Sta Registr | | | 32. Registrar's Signa | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | State of Marylan | | | | | lental Hy | giene | 011 | 2 22071 | | |
|----------------------------|--|--------------|---|--|---|----------------------|-----------------------------|--------------------------------------|--|-------------------------------------|---------------------------|---|--|--|
| | 1 - State Registra MEND#23(A/b)penMD, 6/25/11, BWW, Mcc Certificate of Death 1 December 's Name (First, Middle, Last) 2 Date of Death 3 Time of Death | | | | | | | | 3. Time of Death | | | | | |
| | Physicia | | 1. Decedent's Name (First, Middle, Last) | Mo | | | Month | Day | 4:35am M | | | | | |
| | Medic | al - | Maurice Flemm In Facility Name (If not institution, give si | 4b City | Town or Le | ocation of Death | 067 | 06/19/2012 4c. County of Dea | | | | | | |
| | Examin | er | Holy Cross | | Silver Spring | | | | U | | | | | |
| | Funeral | | 5. Social Security Number 6. Sex | If Unde | f Under 1 Year If Under 24 Hrs. 8. Date | | | th y, Year) | 9. Bir Co | thplace (State or Foreign untry) | | | | |
| | Director | | | X M 2 □ F 91 | Yrs. | WOITEIS | Jujo | , iouio | 11/12 | | | ryland | | |
| | nd now at | _ | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Loc | ation | | 1 | | , | | 10d. Inside City Limits | | |
| | arylar ia-fsl | Director | Md Montgo | mery Po | olsev | ill | е | | | | | 1 x Yes 2 □ No | | |
| | the M or 28 e not | 흐 | 10e. Street and Number | | - | 10f. Zi | Code | | | 10g. Citizen | of What Co | ountry? | | |
| : | with s 23a ust b | Funeral | 19404 Jerusale | n Church Te | | | 2083 | | | | gom | ery | | |
| | 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Ithem 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at | | 11. Marital States | 12. Was Decedent Ever in U.S Armed Forces? | S. 13. W | Vas Dece Yes, spe | dent of Hisp cify Cuban, | anic Origin? (Spe Mexican, Puerto | ecify Yes or No- Rican, etc.) | | Race - Ame Black, Whit | erican Indian, e, etc. | | |
| 36 | after 11", or xamil | d by | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ∐ Yes 2★ No If Yes, Give Year or Dates. | 1 | ☐ Yes | 2 X No | Specify: | | Spec | ify: Bla | ack | | |
| 8 | latura ical E | Completed | 15. Decedent's Edi | ucation | 16a. Decedent's Usual Occupation | | | | | 16b, Kind o | f Business | /Industry | | |
| 212 | n 72 h e. an "r Med | ᇤ | (Specify only highest grad Elementary/Secondary (0-12) | le completed) College (1-4 or 5+) | life. DC | O NOT us | e retired) | ring most of work | ing | Priv | vate | | | |
| Maryland 21215-0036 | within /giene. ner tha t, the N | ပိ | 12th | | Se] | lf_ | Empl | | | L | | | | |
| pu | e filed Ital Hy ed oth event | To B | 17. Father's Name (First, Middle, Last) Richard F. Tall | lev | | | | 18. Mother's Nam Taura | e (First, Middle, L E L | | ame) | | | |
| 75 | should be filed wit and Mental Hygie 'is marked other raumatic event, th | | 19a. Informant's Name/Relationship (Typ | | | | | | | | | | | |
| Ma | 2 sho Ith an 27 is trau | | Walter Talley | Son | 1 | | | | | | | oolseville | | |
| ຜົ | f Health iftem 27 | | 20a. Method of Disposition | 20b. F | Place of Disposemetery, crem | sition (Na | me of | | Date | 20c. Location | on - City o | r Town, StateMd . | | |
| m 0 | Page nent o int: If | | 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, | Removal from State | verdal | | | : | 23/12 | Rive | erDa | le.Md | | |
| Baltimore, | permit, Page 1: Department of I Important: If it any injury or o' | | 21. Signature of Funeral Service License | e | 22 | Name a | nd Address | of Facility neral H | Iome & | Crema | ation | n | | |
| <u> </u> | 9 9 E 8 9 | | Hany Sul S | DF 071 |) [| 5732 | Geo | rgia Av | <u>re NW 1</u> | Washir | igtor | p.DC 20011 | | |
| | Medical Examiner the burial feature the burial feat | | shock, or heart failure. List only on | _ Onsetano Death | | | | | | | | | | |
| | | 7 | Immediate Cause (Final disease or condition resulting in death) | _ Cardiac A | Arryth | nymi | а | | | | | Instant | | |
| | | | resulting in deality | Due to (or as a consequence of the consequence of t | pathy | | _ | | | | | Instana | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of): | | | | | | | | | | |
| | | Examine | cause. Enter Underlying Cause (Disease or injury | <u>Cardiomyopathy</u> | | | | | | | | | | |
| | Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events that initiated events resulting in death) Last Cause (Disease or injury that initiated events that initiated events that initiated events that initiated events that initiate events that initiated events that initiate events that initiated | | | | | | | | | | | | | |
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| 687 | ertifica ding p | Physician/Me | IF FEMALE: | 23c. If yes, outcome of pregna | ancy | | | | | 23d | Date of de | elivery | | |
| Box (| ath ce attend for us | cian | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1 Live Birth 2 Fet. 4 Pregnant at time of | aideath 3 🗌 | Ectopic Other (| | | | | Month | | | |
| œ. | he de y the ached | hysi | 9 Unknown | 9 Unknown | | _ | | | 1 | | | | | |
| P.O. | requires that the death certifics been signed by the attending p should be detached for use as | | Part II. Other significant conditions co | ntributing to death but not res | sulting in the u | underlying | cause give | en in Part I. | | | | to the cause of death? | | |
| ds, | quires en sig ould b | led | | | | | | | | | | Probably 4 Unknown | | |
| Sor | has bei ge 2 sho | Completed by | Hypertension | | | | | | | opsy | | utopsy findings available completion of cause of | | |
| Rec | The lar | Con | | | | | | | 1 Yes | formed? 2 X No | | es 2 🗆 No | | |
| ta | cian: sertific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Louis | ce of Death (Chec | | | | | | |
| f Vi | ding Physician: T th. After this certifica funeral director, p | 2 | 1 Yes 2 XNo | 1 Inpatient 2 2 | 28b. Time of | | 28c. Injury | at Nursing H | ome 5 ☐ Res 28d. Describe | | | ecify) | | |
| O L | th. After Fune | cate | 1 🔀 Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, Year) | injury | М | work? | res 2 🗌 No | | | | | | |
| isio | Atten | Certificate: | 3 Suicide 6 Could not be | 28e. Place of Injury - At h | ome, farm, str | eet, facto | ry, office | | 28f. Location (Street and Number City or Town, State) | | ımber or R | ural Route Number, | | |
| Division of Vital Records, | tal or rs afte al Dire ed in | N C | | | | | | | | | | | | |
| _ | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Medical | (Chook 2 Medical Evami | ician: To the best of my knowner: On the basis of examination | nn and/or inves | stigation, i | n mv opinioi | n. death occurred a | at the time, date | and place, and | aue to the | e cause(s) and marmer stated. | | |
| | the Ithin 2, the Ithin 2, the Ithe Ithe Ithe Ithe Ithe Ithe Ithe | Me | only one Certifying Nurs | e Practitioner: To the best of | my knowledge | e, death o | ocurred at the | e time, date and p | lace, and due to | the cause(s) a | nd manner | as stated. oth, Day, Year) | | |
| | P \$ P 2 | | 29b. Signature and title of certifier | | | 1 - | D286 | | | | | 2,2012 | | |
| | | | 30. Name and address of person who d | ompleted cause of death (Itel | m 23a) (Type I | Print) | | | | | | | | |
| | | | Dr Ravi Passi | | | | RD #1 | 30 Roc | <u>kville</u> | Md 2 | 0850 | | | |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32 Registrar's Signa | ature | who a | 7 | | | | | | | |
| | | | . WILL A C. 'JUI | 1 1 1/2. No. 1 A | re | - | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ Month JALE TALEBI 06/1 Medical 6:30p4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Village at Rockville Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 297-74-9818 1 □ M 2 ⋤ F 88 12/18/23 Turkey (Trabzor show or then "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Gaithersburg Montgamery MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20878 9701 Fields Road, #503 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other then " Elementary/Secondary (0-12) College (1-4 or 5+) Store Room Clerk - Sears Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of Yusuflu Najiyeh Aziz Talebi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 President St., Baltimore, MD 21202 Amir Heyat/Grand-Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Dongation 5 ☐ Other (Specify) 7/14/2012 Rockville, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final /ebrovascolar Awident Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) e buriel-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial_transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DODE 4624 6-18-2012

ROCKNILL, MD 20850 nder 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SANDEEP SHARMA 9701 VEZRS 31. Oate filed (Month, Day, Year) **31.** 25 2012 3. Registrar's Signature State Registrar

Division of Vital Records, P.O. Box 68760

KX

ours after death. Ieral Director: Aft filled in by the fur

24 hours

To the Hosp within 24 hou To the Funel completely fi

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN M. O CONNOR MO SOI W. SEVENTH ST. FREDERICK MD 21701 O'CONNOR 31. Date filed (Month, Day, Yo

Investigation 6 Could not be

determined

Accident Suicide

29b. Signature and the of certifie

4 Homicide

29a. Certifier

(Check

Registrar's Signature Och

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D31761

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:15PM Medical **Examiner** Age (In yrs. last birthday) Yrs. Date of Birth (Month, Day, Year) **Funeral** Director items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 ☐ No 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Forces Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: IRANIAN 1 ☐ Yes 2 ♠ Specify: ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) e 1 and 2 should be filed within 72 is fleath and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) tome MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, Burial 2 Cremation 3 Removal from State PARKAWN Cometery Rockville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MC1388 23a. Part 1. Enter the disease, or complications that caused the death. Do not one of the mode of dying, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) month Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown cate has been signed by the a page 2 should be detached a 9 Unknown 23e. Did tobacco use confribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death 28b. Time of 28c. Injury at work? Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural 1 🗌 Yes 2 🗀 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ June James William Thomas 14 12:23 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9401 Shield Drive Prince George's Upper Marlboro Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Min. Director 579-92-8826 1 2 M 2 D F 48 1963 DC Sept. 17, 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funera 9401 Shield Drive 20772 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Yes 2 X No 1 Never Married 2 X Married 9 Maryland 21215-0036 hours after 1 Yes 2 No Specify. "natural", Specify: African American 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th CCTV-Security Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. Thomas Dorothy J. Gudger and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Mary A. Thomas - Wife 9401 Shield Drive Upper Marlboro, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 2012 Washington, DC Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Derive M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Rectal Cancer disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for sella consequence of: cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed this certificate Yes 2 XNo or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical Certifying Physician: /10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: 10 he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 06-2011

10

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

IUN 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald C. Wheeler 1221 Mercantile Lane Largo, Maryland

32. Registrar's Signatu

D0037529

29d. Date signed (Month. Day, Year)

June 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Month Physician/ June 24, 10:15 A^M Nancy Ann Vetere Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Chesapeake Shores Nursing Center Lexington Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Hours 05-26-1928 New York Director 094-22-1577 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director Lusby 1 Yes 2 X No Calvert. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20657 12326 Santa Cruz Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. r than "natural", or iter the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Maryland 21215-0036 filed within 72 hours after 1 Yes 2 XNo Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Mex Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ဂ္ Jennie Giaiamo Joseph Marotta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12304 Cliveden Street, Herndon, Virginia 20170 Eugene J. Vetere - Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia Metropolitan Crematory 6-25-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin interval Between Onset and Reath Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy autops, performed Vac 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဂ္ this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Month D

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 08 30 PM 2012 Mauricio Octavio Valderrama JUN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL SAINT Baltimore 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛂 M 2 □ F Months Days Hours Min. 4/25/1959 Colombia 578-32-0715 53 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director MD Baltimore 1 🎽 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or Funeral 2816 Walbrook 21216 Avenue USA ritems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 1979

If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married þ ò hours after 1 ☑ Yes 2 ☐ No Specify: Colombian Maryland 21215-0036 White 3 Widowed 4 Divorced "natural", Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n 72 Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Valderrama Octavio Ana Ligia Espinoza 19a. Informant's Name/Relationship (Type, Print) son/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Mauricio Octavio Valderrama 1265 Windmill Lane Silver Spring, Md 20905 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Chesapeake Crem. 1 Burial 2 X Cremation 3 Removal from State 6/21/2012 Beltsville, Md 5 Other (Specify) meral Service Licens PHILIPADES RINALDI FUNERAL SERVICE, P.A. Signatur 9241 Columbia Blvd.Silver Spring, Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final encephaloput days Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner R day s Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Examir CU VS burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial rais Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No To the incorporation of the following after death.

To the Funeral Director. After this certificate Incorporation of the Funeral Director, pag 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🗹 No 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the State Registrar (Check

only one)

3

29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caton 900 Vall Khan, Mohammad 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

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Garks

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

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Baltimore

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2012 6:45 A Calvin Eugene Weishaar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick 8198 Honey Clover Ct. Frederick 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. 1**xx**M 2 □ F Months Hours April 13, 219-20-0841 Maryland 86 1926 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Frederick Maryland Frederick 1 🗌 Yes 2 🎛 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21702 IISA 8198 Honey Clover Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc 1 Yes 2 No 1944 If Yes, Give Year or Dates. 1946 1 Never Married 2XXMarried þ 3altimore, Maryland 21215-0036 white 1 Yes 2x No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) automotive Car salesman injury or other traumatic event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important if item 27 is marked oth
any injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ഉ John Weishaar Elsie Runkles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8198 Honey Clover Court, Frederick, Maryland Helen Weishaar - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 6-18-2012 4 Donation 5 Other (Specify) Prospect Cemetery Mount Airy, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Locensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nalignant Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 🗆 Nursing Home 5 🔀 Residence 6 🗀 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who death 31. Date filed (Month, Day, Year. 32. Red strar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ Robert Jonrowe Whitney June 15, 12:18 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Hospice Dove House If Under 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Day, Year Hours 065-24-4927 89 Director 1 **X** M 2 □ F 1923 New York May 27, 28a-f show 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Director notified Maryland 1 Yes 2 No Carroll Westminster 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 must be 23a Funeral VITH 107 West Main St 21157 USA items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗙 No Specify: Specify. white "natural", Completed 3 Widowed 4 Divorced WWII Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. School the Custodian 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic even မ Harold Whitney Sara Jonrowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 107 West Main St, Westminster, MD 21157 Denneise Whitney, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) rd 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 6/19/2012 Finksburg, MD Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to for as a consequence of If any leading to immedia cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death be detached the signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should been ension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has b death? performe within 24 hours after death.

To the Funeral Director: After this certificate 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Sp. 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the Sulcide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

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State Registrar

31. Date filed (Month, Day, JUN 18

29b. Sign

29d Date sid

| (3 | | | | Plea | se Type or | | | | | | | | | _ | . | |
|-------|---|---|---|------------------------------------|--|--|-------------------------|--|---------------------------|---------------------|---------------|---|--|-----------------------------|-----------------------------------|--|
| 7 | | | For State Registrar | | State o | f Maryla | | partme ertifica: | | | and M | 1ental Hy | gien Reg. N | 201 | 2 | 22080 |
| 80 | Physici Med | | 1. Decedent's Name (F | | | s—Schae | efer | | | | | 2. Date of Death Month Day Year June 19, 2012 | | | | 3. Time of Death 6:08 |
| 7 | 4a. Facility Name (if not institution, give street and number) ATLANTIC GENERAL HOSPITAL | | | | | | | 4b. City, Town, or Location of Death BERL IN | | | | | 4c. County of Death WORCEST | | | |
| 55 | Funera Directo | | 5. Social Security Num 180–26–53 | | 6. Sex 1 □ M 2 🔏 F | 7. Age (In yrs | s. last birthda Yrs | Months | Days | If Under Hours | Min. | 8. Date of Bir Month, Da 03/05 | | 9. B C Was | irthplac ountry) hin | gton, DC |
| 9 | and show 1 at | jo. | Usual Residence of De 10a. State 1 | ecedent 0b. County | | 10c. | City, Town or | Location | | | | | | | 10d. | Inside City Limits |
| 4 | e Maryl r 28a-f notifiec | Director | Delaware 10e. Street and Number | | sex | (| Ocean | | ip Code | | | | 10.0 | 5 14 de -1 C | | 1 🛭 Yes 2 🗆 No |
| 2 | with the 23a of | Funeral [| 38900 Co | | rt | | | 101. 2 | 1997 | 0 | | | rug. C | Ditizen of What C | ountry | r |
| 50 | Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 11. Marital Status 1 Never Married 3 Widowed 4 | | 12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da | rces? 2 🛣 No e | | | | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 08 | 21215-0036 within 72 hours after giene. er than "natural", c., the Medical Exam | Completed by | (Specify Elementary/Second | y only highes | t's Education st grade completed) College (1 | -4 or 5+) | (G life | cedent's Usive kind of we DO NOT us | ork done d se retired) | ation during mos | st of worki | ing | | Kind of Business | | |
| 8 | filed wif | Be | 12 17. Father's Name (Firs | st, Middle, La | ast) | | noii | <u>emaker</u> | | 18. Moth | ner's Name | e (First, Middle | | | | |
| 0 | Maryland 2 should be filed thh and Mental Hy 27 is marked out traumatic event | 욘 | William 1 | | | | 101-1 | -::: A - - | (C4===4 = | | | A. Woo | | or Town, State, Z | 7in Cad | |
| F | hd 2 sho ealth an m 27 is ner trau | | William A | . Scha | | | 38 | 900 C | ove C | | | | w, I | E 19970 |) | |
| 7 | Baltimore, oemit. Page 1 and Department of Her Important: If item any injury or other press. | | 4 Donation 5 | Cremation Other (S) | | State | cemetery, | sposition (Na crematory or ry Cre | other place emato: | ry | 6/22 | 2/2012 | Sa | Location - City of alisbury | , M | D |
| 2012 | Ball permit Depar Impor any in | | 21. Signature of Funer | al Service Li | censee | | | HÖÏTÖV 501 Sr | vay F now_H | unera ill E | äl Ho Rd., | me Pro Salisb | fess ury, | sional A MD 218 | sso 04 | ciation |
| 6 | | | 23a. Part 1. Enter the shock, or heart for Immediate Cause (Fin | ailure. List o | nly one cause on ea | gh line. | ~ | . 0 | de of dying | g, such as | cardiac o | or respiratory a | rrest, | | In | oproximate terval Between nset and Death |
| 9 | Physician Medica Examine | 1 | disease or condition resulting in death) | 1 | a | or as a conse | | ue (| | | | | | | | |
| 00 | ed sit | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | | | | | |
| 00 | ox 68760 ath certificate be executed attending physician and for use as the burial-transit | ज | that initiated events resulting in death) Las | | c. Due to (| or as a cons | equence of): | | | | | | | | | |
| 0 | 68760 ertificate b ding physise as the b | Med | IF FEMALE: | | | · | | | | | | | | | | |
| 193 | Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate b 24 hours after death. Funeral Director. After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the L | Completed by Physician/Medic | 23b. Was decedent proint the past 12 mo 1 Yes 2 19 Unknown | iths? | | Birth 2 🗆 F nant at time o | etal death | 3 | | _Б у | | | | 23d. Date of d Month | elivery Da | ıy Year |
| 10 | ords, P.O. B. requires that the de been signed by the should be detached | by Ph | Part II. Other significa | ant conditio | ns contributing to d | eath but not | resulting in t | ne underlying | cause giv | en in Part | t I. | | | use contribute | | |
| ico | Records, The law requires ate has been sig | leted | | , | | | | | | | | 24a. Was | an | 24b. Were a | utopsy | findings available |
| 0 | Recc The law cate has | | | | | | | | | | | auto perf | ormed? | death? | | letion of cause of |
| 0 | ital sician: certifi rector, | Be | 25. Was case referred examiner? | 7 | Hospital: | / | | | Othe | ar- | ath (Check | | | - [] | | |
| | of Vital ing Physician: After this certific uneral director, | ate: To | 27. Manny of Death | 5 🗌 Pendin | 28a. Date | Inpatient 2 of injury th, Day, Year) | 28b. Tim | e of y | 28c. Injury work | 4 ⊔ N y at .? | | ome 5 LResi 28d. Describe | | 6 Other (Speury occurred | ecify) | |
| X | Division al or Attendir s after death. Il Director: After death of the full by the full death. | Certificate: | 2 Accident | Investig 6 Could r determi | ot b 28e. Place | Injury - At | | M street, facto | | Yes 2 | | 28f. Location (| | and Number or R te) | ural Ro | oute Number, |
| URE | Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page | Medical C | (Check 2 | Medical E | Physician: To the b | of examina | tion and/or ir | vestigation, in | n my opinia | on, death o | occurred at | the time, date | and plac | ce, and due to the | e cause | (s) and manner stated. |
| I | To the within To the comple | Σ | only one) 3 L 29b. Signature and title | | Nurse Practioner: | To the best of | my knowled | | c. License | e number | | e, and due to the | | e(s) and manner a | | |
| 18 | | | 30. Name and address | s of person v | 1) | e of death (It | em 23a) (Typ | e, Print) | | 361 | | 0 , | | 119/12 | <i></i> | 1 8 |
| 3 | | ate | 31. Date filed (Month, | | 0040 0 | eglstrar's Sig | 1 +35 natur g | HEA | 1940 | Nax | W | Berli | n | UD 2 | 18/ | / |
| 1KWS. | Regist | rar | | JN 26 | 2012 | me | P. 1 | ASS. | | | | | | | | |
| 3 | DHMH 17 Rev 7/ | 2009 | | - | | | ORI | GINAL | | | | | | | | |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 218RM GEORGE BRYAN WILLISON 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death REGIONAL Medical Cento 54456419 PENINSULA HICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 218-66-0560 1 X M 2 □ F 56 FEB. 12, 1956 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 Tes 2 No KENT WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25690 MEADOW ROAD 21678 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates WHITE ital Hygiene. ed other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) DRYWALL INSTALLER CONSTRUCTION Be ft. Page 1 and 2 shoulo ב... artment of Health and Mental H-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GEORGE** WILBUR WILLISON BARBARA SMOOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDY D. WILLISON/BROTHER 10303 CATHELL ROAD, BERLIN, MD 21811 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it 1 Burial 2 X Cremation 3 Removal from State permit. Page Department CREMATORY OF DELMARVA 4 ☐ Donation 5 ☐ Other (Specify) 6/24/12 DELMAR, DELAWARE 21. Signature of Furieral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Laratid Physician/ luptured disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner arrent Sequentially list conditions, if any, leading to immediate Examine The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? δ page 2 should be Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After this certific. completely filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) ιê 1 Tes 2 No Other: 1 DOA Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending Division 1 Yes Investigation 6 Could not be 2 🗌 No ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital of within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 2 3 D66198 6 ess of person who completed cause of death (Item 23a) (Type, Print) 310 100 EAST CAPROLL STREET, SALISBURY, JUSTINIA NGALZA 31. Date filed (Month, Day State

DHMH 17 Rev 06-2011

Registrar

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Physician/ R. Walston Ellen 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Willomica huri at If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Hours Min (Month, Day, Year) 216-56-1471 Director 1 🗆 M 2 🔀 F 57 04/03/1955 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified et 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 1704 Camden Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 X Married Completed by と | | とか | 似 | | S かい Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Media Specialist Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline Elouise Downing Richard M. Walston 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any injury or other treum: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1704 Camden Ave., Salisbury, MD 21801 Edward C. Otter/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 6/25/2012 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) LFuneral Service Licensee HOLLOWay Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Rom 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT VARIAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir the burial-transif that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence HOSPICA 1 Inpatient 2 I ER/Outpatient 3 I DOA

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.
Funeral Director. After this certificate has been signed by the setely filled in by the funeral director, page 2 should be detached

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Certificate: Medical within 24 hou **To the Funer** completely fil 15TC

State

1 ☐ Yes 2 ☐ No 27. Manner of Death 29a. Certifier (Check

only one

29b. Signature

Natural 2 Accident Suicide 4 Homicide

and title of certifier

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be determined

injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28b. Time of

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atterpus

31. Date filed (Month, Day, Year) 25

20

DHMH 17 Rev 06-2011

Registrar

1300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26 per FH TT 6/27/12

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01vin Harlan Wilkerson 12:00P M 2012 June Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Suitland, 4812 Bennett Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**x**□ M 2 □ F Days Hours Min. Months Jul. 14 1926 Virginia Director 85 225-22-4223 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Suitland MD Prince Georges 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral United States 4812 Bennett 20746 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Search Advisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie White Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Samuel Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a 4812 Bennett Ave. Suitland MD 20746 Vanessa Wilkerson/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20a. Method of Disposition ^D替/26/ Cheltenham, MD June6/12 Che1tenham Signature of Euneral Service Licensee CC0418 22. Name and Address of Facility 2504 28th St N.E. Washington, DC DC Bonnette & Associates Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CARDIOMYORATHY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) HYPERTENSION Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ KIDNEY Records, 1 Yes 2 No 3 Probably 4 Unknown Completed DI ABSETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy performed 2 No or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\to\) Nursing Home 5 \(\textbf{X}\)Residence 6 \(\to\) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 53885 M 10

Registrar DHMH 17 Rev 7/2009

State

SURMATTS

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ R. Williams Month Barbara +:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mata edica har If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 577-62-7878 65 **Director** 1 M 2 XX 07/21/1946 Washington, DC or 28a-f shov Department of Health and Mental Hygiene. Important: frems 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince George's Oxon Hill 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5914 Terrell Avenue 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes **2XX**No If Yes, Give Year or Dates. MCMS, SarbarcBaltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. 3 Widowed 4 Divorced Specify B1ack 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Surgical Supervisor Wash. Hosp. Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gladvs Robinson Haddock Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5914 Terrell Avenue Oxon Hill, Maryland 20745 Brandye Williams / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/21/2012 | Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_ysician/ disease or condition resulting in death) metostunc Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of and I-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown signed by the To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? death? 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 269566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MichelMDS Garrett Avenue, La Plata, MD Date filed (Month, Day, Year) JUN 2 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Maureen Mavis Warner 1:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Country 216-20-0582 Director 1 □ M 2 🔀 F 85 29,1926 Maryland Usual Residence of Deced 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington 1 Yes 2 No *Hagerstown* 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n 23aFuneral 13636 Poplar Grove Rd. 21742 U.S.A. items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc ò þ 1 Never Married 2 Married Yes 2 X No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White and Mental Hygiene. is marked other than "natural", 3X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Secretary Healthcare permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur McBride Marie Brown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott M. Warner 13636 Poplar Grove Rd. Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State June 30 Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Crematory 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph_{sician} disease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed Yes 2 certificate 2 1 No 1 Yes 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at s after death. 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Tyes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signatur 30. Name and Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | _ ' | State Registrar | | , | Cer | tificate of L | Death | , | Reg. N | . 20 | 12 | 28 | 208 | |
|--------------------------------|--|-------------------|--|---|---------------------|---------------------|---|-------------------------------|--|------------------|--------------------------------|--|---------------------------------------|-----------------------|--|
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Las | st) | | | | | 2. Date of De | | Day | Year | 3. Time | | |
| | Medic | al | SOPHIA ANN WEST 4a. Facility Name (if not institution, give | # 6" T | 1 (0) | JUN | 15 | 20 | 012 | 9:05 | A M | | | | |
| | Examin | er | WALTER REED NATIO | | L CENTI | ER | 4b. City, Town, or Location of Death BETHESDA | | | 4c. County of Do | | | RY | | |
| | Funeral Director | | | ex 7. Ag | e (In yrs. last bir | thday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Heyrs Min. | 8. Date of Bi | | 012 | | ace (State rylar | or Foreign nd | |
| | nd ihow at | 'n | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Loc | ation | | | | | 10 | 10d. Inside City Limits | | |
| | Maryla 28a-f stified | rect | VA Arling | ton | | Ar1 | ington | | | | | | 1 □ Y€ | es 2 🗷 No | |
| | s 23a or 2 | Funeral Director | 10e. Street and Number 3900 Columbi | a Pike | #301 | | 10f. Zip Code 22204 | | | 10g. C | Citizen of Wh | nat Countr | y? | | |
| 9036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importantial file m 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by | 11. Marital Status 1 → Never Married 2 → Married 3 → Widowed 4 → Divorced | 12. Was Decedent B Armed Forces? 1 Yes A If Yes, Give Year or Dates. | Ever in U.S. No | | /as Decedent of H Yes, specify Cuba ☐ Yes 2 💢 No | | oecify Yes or No o Rican, etc.) | Î | 14. Race Black, Specify: | White, et | | | |
| 1215-(| thin 72 hou ene. than "natu he Medica | Completed | 15. Decedent's Elementary/Seconday (0-12) | | | (Give k life. DC | ent's Usual Occup ind of work done o NOT use retired) | ation during most of wor | king | 16b. | Kind of Bus | | ıstry | | |
| Baltimore, Maryland 21215-0036 | and 2 should be filed within 7. Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Ms | ادہ ا | 17. Father's Name (First, Middle, Last) | p West | | IVC | ne | 18. Mother's Nar | me (First, Middle ulia Ro | | | | | | |
| , Man | nd 2 should salth and h n 27 is ma er trauma | | 19a. Informant's Name/Relationship (7) Philip West/Fath | | | | g Address (Street a | | | - | or Town, Sta | | ode) 2204 | | |
| imore | . Page 1 ar tment of He tant: If iter jury or oth | | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conten | | cemete | ery, crem | sition (Name of atory or other place enatory | ee) 6/2 | Date 2/12 | - | Location - C Ls Chun | * | | | |
| Bail | permit. Departr Importa any inju | | 21. Signature of Funeral Service Licens | see | 112/25 | | Name and Addres Murphy F. | | ilson B | lvd. | Ar1i | ngtoi | a. VA | 22203 | |
| | Physician/ Medical Examiner | | 23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | ne cause on each line | 2 . | URI | | g, such as cardiac | or respiratory a | rrest, | | 1 | Approxima Interval Be Onset and | etween | |
| 0 | tificate be executed ng physician and as the burial-transit | ical Examiner | Sequentially list conditions, if any, leading to immediate the second of the sec | c | a consequence | | | | **** | | | | | | |
| . Box 68760 | ath certific attending for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XNo 9 ☐ Unknown | 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown | 2 Fetal deat | | Ectopic pregnanc Other (specify) | y - | | | 23d. Date Mont | | y Day | Year | |
| ds, P.O. | requires that the de been signed by the should be detached | by | Part II. Other significant conditions of | ontributing to death b | ut not resulting | in the ur | nderlying cause giv | ven in Part I. | | | use contrib | _ | | | |
| Records, | The law recate has being page 2 sho | Completed | | | | | | | 24a. Was auto perfe 1 \square Yes | opsy ormed? | pri de | ere autops or to com ath? Yes 2 | y findings pletion of | available cause of | |
| a | sician; The certificate I | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | | Othe | ace of Death (Che | | | | | | | |
| o | g Phys er this neral dii | te: To | 27. Manner of Death | 1 X Inpatie 28a. Date of injur (Month, Day | | Time of | 28c. Injury | 4 □ Nursing F ≀at | ome 5 Resi 28d. Describe | | | (Specify) | | | |
| 0 | tending leath. or: After the funer | Certificate: | 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b | | r, rear) | injury | M 1 🗆 | Yes 2 No | | | | | | | |
| Division of Vital | ortal or Attendurs after death ral Director: / | | 4 Homicide determined | building, etc | (Specify) | | | | 28f. Location (City or Tou | wn, Stat | e) | _ | oute Num | ber, | |
| | Hospital | ledical | 29a. Certifier 1 X Certifying Physics (Check 2 Medical Examination only one) 3 Certifying Nursi | sician: To the best of ner: On the basis of ex- | kamination and/ | or investi | gation, in my opinic | n, death occurred | at the time, date | and plac | e, and due to | the caus | e(s) and m | anner stated | |
| | io the Hos within 24 h To the Fun completed | Σ | 29b. Signature and title of certifier |) | Sest Of THY KIROW | nouge, a | 29c. License | | ice, and due to tr | | ate signed (i | | - | | |
| | As a | | 1 200 | e e | | | | D 707 41 | | | JUN 15 | | | | |
| | MI | | 30. Name and address of person who | mpleted cause of de | eath (Item 23a) | (Type, Pi | int) WALTER | | TIONAL | MED] | CAL C | ENTE | R | | |

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22087 Certificate of Death Reg. No. 3. Time of Death
52 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RNEST MARTIN WEAVER JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE VA MEDICAL CENTER BAL TIMORE If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) 217-54-7772 Director 1 M M 2 □ F Jan. 6, 1950 PA 62 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a, State 10c. City, Town or Location Director must be notified Seven Valleys 1 Yes 2 X No PA York 10e Street and Number 10g. Citizen of What Country? 23a Funeral 17360 3626 Shaffers Church Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No 1967

If Yes, Give
Year or Dates. 1971 Black, White, etc. 0 à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Yes 2 No Specify: White Specify: "natural", 3 Widowed 4 X Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Veteran U.S. Military 12 should be filed with and Mental Hygien is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Betty A. Delozier James E. Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a 3626 Shaffers Church Rd. Seven Valleys Pa 17360 Jedediah Steiner/Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date remation Direct July 1 Burial 2 Cremation 3 Removal from State injury or Department (Important: Il any injury or York, PA 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility JJ Hartenstein Mortuary, Signature of Fu eral Service License 1-M N. Second St. New Freedom, PA 17349 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PARAPNEUMONIC EFEUSION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Die to (or as a consequence of) OPD Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical TOBALLO USE certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Records, ATRIAL FUTTER 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number AIPI 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

Macheny Sher

MACKENZIE

31. Date filed (Month, Day, Year)

JUL 1 2 2012

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHURT

1518192368

27 SOUTH GREENE ST, DALTIMORE, MD ZIZO)

June 29 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Kimber 1V Winston June 13. 10:42 ptm Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Emmitsburg 9119 Waynesboro Pike 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Feb. 5ay, Yel 963 Gettysburg, PA 169-56-6407 49 Director Usual Residence of Decedent 28a-f shov notified at 10a State 10c City Town or Location 10d Inside City Limits Director 1 XYes 2 No MD Frederick Emmitsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Examiner must be 23a 21727 USA 9119 Wavnesboro Pike 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. ŏ þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) / Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Graphic Company Laborer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of ٥ Carol Woodward Donald Koontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 4236 Old Harrisburg Rd., Gettysburg, PA 17325 Jeremy Winston, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-19-2012 Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Emmitsburg Cemetery 22. Name and Address of Facility JL Davis Funeral Home 21. Signature of Funeral Service Licenses 12525 Bradbury Ave., Smithsburg, MD 21783 Party the is shock, heart fa ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 L 25. Was case referred to pedical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: To the Hospital or Attending Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Date Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 2012 Year JUNE 11:02aM RUTH SWARTLEY WILLIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Smith Creek Assisted Living Warwick 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2**X** Months Days Hours NOV 13 1927 Pennsylvania Director 84 192-20-2260 Usual Residence of Decedent or 28a-f show at 10c. City. Town or Location 10d, Inside City Limits the Maryland Director be notified 1 Yes 2 XNo Frankford DE Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [and Mental Hygiene.
Is marked other than "natural", or items 23a raumatic event, the Medical Examiner must b 19945 U.S.A. 33372 Burton Farm Rd. and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl A. Swartley Emma Cressman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Willis (son) 27960 Wallis Rd. Kennedyville, MD. 21645 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1; permit. Page 1
Department of 1
Important: If it
any injury or o
once. cemetery, crematory or other place)
Eastern Shore Bible
Baptist Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Bemoval from State 6/26/12 Galena. MD. 4 Donation 5 Other (Specify 21. Signature of Funeral Service ²² Name and Adgress of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 Port . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cau (Final disease or condition Onset and Death Physician/ years Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Medical Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Living 2 No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ap the of certifier 29d. Date signed (Month, Day, Year) 6.25.20/2. Sachder 5 mg

Registrar DHMH 17 Rev 7/2009

State

High ST, Elkin MD 21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print S.S SACHDEV MD, 126A, E +

SACHDEN MD

31. Date filed (Month, Day, Year)
JUL 1 2 2012

Please Type or Print in Black Indelible Ink. 3 Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 22090

| | | 1- For State Registrar | - | Cert | tificate of | Death | | R | eg. No. | U I | | | |
|--|----------------|---|--|----------------------|------------------------------|---|---------------------------------------|-----------------------------|---|------------------------------|---|--|--|
| Physici ledical Exam | | Decedent's Name (First, Middle, | | | | | 2. Date of Dea Month June 28, 2 | ith | ar | 3. Time of Death 0743 hrs | | | |
| | | 4a. Facility Name (if not institution, Baltimore Washington | | | 4 | b. City, Town, or L Glen Burnie | ocation of Dea | th | 4c. County of Death Anne Arundel | | | | |
| Funeral Director | | 010 00 0000 | 5. Sex 7. Age | 9 (In yrs. Ias 52 | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24Hi Hours Mi | _ | | | | | |
| and f show any nce. | or | Usual Residence of Decedent 10a. State 10b. County MARYLAND BALTIN | MORE | | Fown or Location | n | | | | | 10d. Inside City Limits 1 Yes 2 X No | | |
| the Maryl is or 28a- | Director | 10e. Street and Number 566 S. BEECHFIEI | LD AVENUE | | | 10f. Zip Code 2122 | 9 | 1 | 0g. Citizen of Wh | nat Coun | itry? | | |
| fter death with 1", or items 23 | y Funeral | 11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divor | 1 Yes 2 | Ever in U.S | If Ye | Decedent of Hisp s, specify Cuban, Yes 2 X No | | | | e - Americ e, etc. WHI | can Indian, Black, | | |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-fabs matic event, the Medical Examiner must be notified at once | Completed by | 15. Decedent's Education (Specific Elementary/Secondary (0-12) | y only highest grade com College (1-4 or 5 | | | s Usual Occupationst of working life. | | | 16b. Kind of Bu | | ndustry | | |
| 21215-0036 ould be filed within 7 i Mental Hygiene. s marked other than ic event, the Medica | Be Con | 17. Father's Name (First, Middle, L ROBERT MILTO) | • | | | 18 | | e (First, Middle, ME CAROL) | Maiden Surname) E SCOTT |) | | | |
| ore, MD 21 es 1 and 2 should of Health and Me If item 27 is ma | ¹ | 19a. Informant's Name/Relationship JOANNE C. EMKEY | | | 34129 | Address (Street POCAHON | TAS RD, | DAGSBOR | RO, DE. 1 | 9939 | | | |
| Page Page | | 20a. Method of Disposition 1 Burlal 2 Cremation 4 Donation 5 Other Spec | cify: | te cre | son's c | REMATORY | 7 7-2 | Date 2-2012 | | • | DELAWARE | | |
| | | 2 . Signat e of Fuhr ice Li | - | | 43 | LSON FUN THATCHE | R STREE | T, FRANK | CFORD, D | | | | |
| Physician /Medical Examiner | | 3a. Part List only one cause or Immediate Cause (Final disease or condition resulting in death) | a. Cardiome | c Arr galy | hythmia with B | 1 | | | | π | Approximate Interval Between Onset and Death | | |
| | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consect b. | | | | | | | _ | | | |
| red) | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | | | |
| 760, ficate be executed g physician and the burial - transit | /Medical | X UNPENDED | x AMENDED 23a #23a.pt.11 | .pt.1 | I,27 pe | er me g9 | 30 8-24 32 9-24 | -12 vt 7-12 sm | Lood Bata of | | | | |
| cords, P.O. Box 6875 law requires that the Jeath certificate has been signed by the attending phy 2.2 should be detached for use as the l. | Physician/M | 23b. Was dece∈ent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown | 23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown | | 2 Feta | I death 3 | Ectopic pregn | ancy | 23d. Date of Month | Da Da | ay Year | | |
| P.O. Es that the igned by the detached | ã | Part II. Other significant condition Hypertension | <u> </u> | | • | | en in Part I. | 1 _ | | _ | ne cause of death? | | |
| of Vital Records, ig Physician: The law require this certificate has been sineral director, page 2 should the control of the c | Completed | Possible drug | | | | | | 24a, Was a autopa perfor | sy pi med? de | | opsy findings available ompletion of cause of | | |
| Vital Rechysician: The lathis certificate if director, page | o Be C | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Inpatien | ıt 2 √ E | R/Outpatient | | f Death (Check | | Residence 6 | | | | |
| _ # ^ ₽ I | \vdash | 27. Manner of Death 1 X Natural 5 Pending | 28a. Date of Injun (Month, Day,Yes | y 2 ar) | 28b. Time of Inju | ury 28c. Injury | | | now injury occurre | | | | |
| Division pital or At ours after deral Direct filled in by | Certification: | 2 Accident Investig 3 Suicide 6 X Could r 4 Homicide determi | 28e. Place of Injuned (Specify) Fd | ry - At hom | ne, farm, street, ospital | factory, office buil | 7 | MedicaT | tate)Baltin Center | 301e | al Route Number, City Washington Hospital Dr | | |
| To the Hos within 24 h To the Fun completely | edica | | sician: To the best of my ner: On the basis of exam and manner stated. | | | | | | | | | | |
| | Me | 29b. Signature and title of certifier | ue) | | | | | | | | 29d. Date signed (Month, Day, Year) June 29, 2012 | | |
| | | | istant Medical Exar | miner 9 | 900 W. Balt | imore Street, | Baltimore, | MD 21223 | ===:::::::::::::::::::::::::::::::::::: | | | | |
| St Regist | | 31. Date filed (Month, Day, Year) | 2012 32. Registrar's | s Signature | 1. ba | Kel | | | | | | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:40p M Vincent Joseph Zito, Sr. 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Golden Living Center 9. Birthplace (State or Foreign If Under 1 Year If Under 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, (Month, Day, Yea Mar. 23, **Funeral** Days Year Hours 219-16-9884 Maryland Director 1 🗶 M 2 🗆 F 87 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Westminster 1 X Yes 2 No Carroll Maryland 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be United States Funeral 21157 26 1/2 Green Street death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 194
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1946-Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: white 3 X Widowed 4 □ Divorced Completed 1948 Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

pipe fitter (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) plumbing olth and Mental Hygie 27 is marked other r traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Elizabeth Nuth ဂ္ Vincent Zito, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Westminster, Maryland 21157 Gladys E. Linger / daughter 26 1/2 Green Street 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Gdns. June 20, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Finksburg, Maryland 4 Donation 5 Other (Specify) 2012 22 Name and Address of Facility 21. Signature of Funeral Service Licens Eline Funeral Home Hampstead, MD 21074 Main St., S. urvs 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kireare Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the attent in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has lirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) B 25. Was case referred to medical Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 은 1 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work?
1 Yes 2 🗌 No Accident Investigation after death

Director: A
d in by the f Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date/signed (Month, Day, Year) H0061206

State

Registrar

30. Name and address of person

0 2012

2

Registrar's Signatu

e Rd. Westminster

31. Date filed (Month, Day, Year, State Registrar

Pamela E. Southall, MD

Assistant Medical Examiner 32. Registrar's Signature

30. Name and address of/person who completed cause of death (Item 23a)

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2012^{ea} Physician/ Galina Adamovich 8 2131 М Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 11/25/1930 220-41-0679 81 Director 1 □ M 2 X F Russia ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🅅 No Elkridge Maryland Howard 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 21075 Russia 6335 Arbor Way ral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify: White of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Lidia Popova Emelian Popov permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 Pennell Court Elkridge, Maryland 21075 Alexander Adamovich 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Holy Trinity Cemetery 07/14/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mrzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muhael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OLON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of): and Il-transit that initiated events Due to (or as a consequence of): resulting in death) Last 24 hours after death. Feet this certificate has been signed by the attending physician as Funeral Director. After this certificate has been signed by the attending physician as a funeral director, page 2 should be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 2 🔀 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Medical Certificate: injury 1 🔀 Natural 5 Pending 2 🗌 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific JULY 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044 6336 DOBERMAN, MD DANIEUE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gust J. Asimakes 9 2012 9:52 PM July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death n/a 2713 Kildaire Baltimore 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 X M 2 □ F Months Hours 84 **Director** 216-20-5690 February 5, Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States of America 2713 Kildaire Road 21234 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

XXYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Restaurant 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Helen Plainous John A. Asimakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. Nancy Asimakes - Spouse 2713 Kildaire Road, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Demotrics Greek
Orthodox Ouron Greek 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland 4 Donation 5 Other (Specify) July 13, 2012 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause n each line. Immediate Cause (Final Physician/ na disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 1 Yes 2XXNo 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 👿 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d, Date signed (Month, Dav. Year) H 46961 2012 who completed cause of death (Item 23a) (Type, Print) Salome Hawkins-Cole, DU.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Sheridan Ambrose Po 3:25 Pm July 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Year) Director 212-42-0304 1**XX**M 2 □ F 68 March 10, 1944Dist.ofColumbia Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3029 California Ave. 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: white Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 builder construction Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phyllis Montgomery Ernest Philip Sheridan Ambrose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary B. Ambrose/wife 3029 California Ave. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory July 17,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Miltoner 11 Wiedereld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ Small cell Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) -∡xaminer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760⁷ IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy this certificate had rail director, page 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{Other (Specify) \(\text{NDS PLCE} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No eral Director: A filled in by the fo Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 5 ss of person who completed cause of death (Item 23a) (Type, Print) TONSON CHARLES m 6701 31. Date filed (Month, Day, JUL 13 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 James C. Allen Sr. July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3480 8. Date of Birth (Month, Day, Year Old Crown Dr. Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 🕅 M 2 🗆 F Hours Yrs Director 69 219-38-5683 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Md. Anne Arundel Pasadena 1 🗌 Yes 2 😾 No 10e Street and Number 10f. Zip Code ò 10g, Citizen of What Country? ms 23a or Funeral 3480 Old Crown Dr. 21122 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examinations. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Sales Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Justin Allen Finley Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Allen 3480 Old Crown Dr. Pasadena, Md. 21122 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Brooklyn, Md. Cedar Hill Cemetery 7/16/12 Donation 5 Other (Specify) 21. Signature f Fungral Service 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Maryland 21122 sease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, live. List only one cause on each line. 23a. Part 1. Enter the of shock, or heart fail Interval Between Immediate Cause (Final Onset and Death Physician/ ano disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performe this certificate has 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 2 Acciden 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 Hospital on. Glan Burn Mar 32. Regist ar's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ 10:02 PM 20/2 Medical 4b. City, Town, or Location of Death Examiner ledical Cer If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Funeral Davs Country) Hours 220-56-0382 Director 1 🗓 M 2 🗆 F MD 12-10-1950 Usual Residence of Decedent ir than "naturel", or Items 23e or 28e-f show the Medical Expiring must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State death with the Maryland Director 1 Yes 2 No Pasadena Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21122 7851 Mansion House Crossing 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. id Mental Hygiene. marked other than "naturel", or l 1 Yes 2 X No Completed by 1 Never Married 2 K Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **CPA** Accounting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be Katherine Perry Ellsworth Appler permit. Page 1 and 2 should Department of Health and M Importent: If item 27 Is mar eny injury or other treumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7851 Mansion House Crossing, Pasadena, MD 21122 Michele Appler - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State 07-09-2012 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Maral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician/ disease or condition Medical resulting in death) [']Examiner DIVERTICULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of sician and burial-transit Hospital or Attending Physiclen: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 **\$** use as t attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 1 Yes 2 No the th P.O. ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ACUTE RENAL FAILURE, AYPERKALEMIA Records, 1 Yes 2 No 3 Probably 4 Unknown Completed THROM BO CY TOPENIA HYPERBILIRUBINEMIA 24b. Were autopsy findings available prior to completion of cause of death.

1 ☑ Yes 2 ☐ No 24a. Was an certificete 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this thin 24 hours after death.

the Funeral Director: After this impletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hound to the form the formula completely file 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00041284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAY MUNDO CAPARROS, M. D 31. Date filed (Month Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathbf{J}^{ ext{Month}}_{\mathbf{U}}$ 2012 5:00 Ido Adamo 7, Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care Potomac Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 T + 0 1 TT **Funeral** Days Months Hours Min November 7, 079-34-9796 82 Yrs Italy Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 10901 Balantre Lane 20854 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Private Practice Medical Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Antonella Pedone Julio Adamo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Eveyln Adamo / Wife 10901 Balantre Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State July 11, 2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery permit. 21. Signatur viru in 15 rvice Licensec Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cerebrovascular Accident disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, Due to for as a consecuence of cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director; After this certificate has been signed by the attending physicial IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Prystorian. The within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2.8 autopsy 2 No Yes 2 X N 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury X Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be

P.O. Box 68760 Division of Vital Records,

State Registrar

Medical

Thomas Masterson, M.D. 31. Date filed (Month, Day, Year) 3 2012

determined

4 Homicide

29a. Certifier

(Check only one) 29b. Signature and title of certifie

> 1390 Chain Bridge Road #900, McLean, Virginia 22101 32. Registrar's Signature racke

Momas Masterson Mr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

July 9, 2012

City or Town, State)

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D50534

29c. License number

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 7:15 AM Gloria G. Albinak Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Cente Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Months Days Hours Min. 371-38-8006 Director 1 🗆 M 2 🗓 F 78 Sept. 16 1933 Michigan Usual Residence of Deceden 28a-f show 10b. County 10c. City. Town or Location 10a. State Director 1 Yes 2 K No Towson Maryland Baltimore 10e. Street and Numbe 10f Zin Code 10g. Citizen of What Country? 5 23a 21204 U.S.A. 8205 Robin Hood Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc þ 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Co. Govt. Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Beckham Joseph Galamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2829 N. Calvert St., Baltimore, Maryland 21218 Anne Albinak / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2X Cremation 3 Removal from State Towson, Maryland 7/13/2012 HilltopServiceCorp 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck towson Funeral Home, Inc. Signature of Funeral Scruter Licel 1050 York road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Schemie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical the L Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a, Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After t Natural 5 Pending Investigation within 24 hours after death To the Funeral Director: A completely filled in by the Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0058082 npleted cause of death (Item 23a) (Type, Print) N-Pavillion Suite 550 Towson MD 21204 harles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Deathy 40 ounty of Death **Funeral** 9. Birthplace (State Country) 8. Date of Birth Months Min. (Month, Day, Year) **Director** 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 □ No ò 10g. Citizen of What Country? 23a c Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ Black, White, 1 Never Married 2 No Specify: Baltimore, Maryland 21215-0036 1 🗌 Yes "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17, Father's Name (First, Middle, Last) ည injury or other traumatic 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the shock, or heart disease, or complications that caused allure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final of Onset and Death Physician/ ncer disease or condition resulting in death) yea-Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or Injury that initiated events Due to for as a consequence on requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the IF FEMALE: es, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? Pregnant at time of death Other (specify) Month Year ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospita 1 Tyes 2-No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1--Natural Accident Investigation 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

living Stan

Black Irma

| | | | Pleas | e Type or Pr | | | | | | | gible. | | |
|----------------|---|------------------|--|---|------------------------------|-------------------------------|---|-------------------|--|------------------------|---|-----------------------|--|
| | | | For State | State of M | /larylan | | artment of F <i>tificate of L</i> | | nd Mental Hy | 21 | 012 | 2210 | |
| | | | Registrar 1. Decedent's Name (First, Middle, L | ast) | | 001 | uncate or L | Jeann | 2. Date of D | Reg. No eath Day | 3. 7 | ime of Death | |
| *** | Physici: Medi | | Irma Jacqueline Black | | | | | | | | apria 5 | 30 PM | |
| | Exami | ner | 4a. Facility Name (if not institution, gi | | - 1 | 1 | 4b. City, Town, or | 1 1 | Death | 4c. Count | 1 | | |
| | Funeral | | Franklin Squa 5. Social Security Number 6. | | | ast birthday) | R O SC (If Under 1 Year Months Days | If Under 24 | | irth | + im or 9. Birthplace (\$ | State or Foreign | |
| | Director | ı | 210-09-8010 Usual Residence of Decedent | 1 □ M 2 X F | 95 | Yrs. | Months Days | riouis | Min. (Month, D | | Country) Pennsylv | vania | |
| | /land f show ed at | tor | 10a. State 10b. County | | 10c. City | y, Town or Loc | cation | | 110/20/ | 1510 | | side City Limits | |
| | r 28a- notifie | Direc | MD Baltir 10e. Street and Number | nore | Ba | altimo | | | | | | ☐ Yes 2X No | |
| | with the Maryland 23a or 28a-f sho ust be notified at | Funeral Director | 8800 Walther B | vd. | | | 10f. Zip Code 21234 | | | 10g. Citizen of U.S.A | | | |
| | death r items ner mu | | 11. Marital Status | 12. Was Decedent Armed Forces? | | 5. 13. V | | | n? (Specify Yes or No Puerto Rican, etc.) | - 14. Rad | ce - American Indi | an, | |
| 036 | 72 hours after n "natural", or ledical Exami | d by | 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 1 Yes 2 If Yes, Give Year or Dates. | No | | ☐ Yes 2 X No | | Dia | Specify: White | | | |
| 21215-0036 | 2 hour "natu edical | Completed | 15. Decedent's (Specify only highest of | Education | | 16a. Deced | ent's Usual Occupa ind of work done of | ation | f working | | Business/Industry | | |
| 121 | within 7 giene. er than , the Me | Com | Elementary/Secondary (0-12) | College (1-4 or | 5+) | life. DO | NOT use retired) | | | Univers | sity of nd Law So | ahaal | |
| | filed wall Hyg al Hyg d othe | Be | 17. Father's Name (First, Middle, Last |) | | ACIILLI | IISCIACIV | | s Name (First, Middle | | | HOOL | |
| Maryland | should be filed wit and Mental Hygie is marked other aumatic event, th | 욘 | Paul Carl Prato | | | | | Pier | rina Cassi | notti | | | |
| | 4 27 ± 24 | | 19a. Informant's Name/Relationship Kathryn L. Schr | | nter) | | | | or Rural Route Numb - Westmin | | | 21157 | |
| ore, | of Heal | | 20a. Method of Disposition 1 Burial 2 X Cremation 3 | | 20b. Pi | lace of Dispos | sition (Name of latory or other place | | Date | | - City or Town, St | | |
| Baltimore, | permit. Page Department Important: I any injury o | | 4 Donation 5 Other (Spec | cify) | | ro Cre | matory, : | Inc. 0 | 7/12/2012 | | | | |
| Ba | permit. Departr Importa any inji | | 21. Signature of Funeral Service Lice | 1 (| | | | | E. F. Lass ad - Kings | | | • | |
| п | | | 23a. Part 1. Enter the disease, or co- shock, or heart failure. List only | nplications that cause | d the death | | | | | | Appro | eximate al Between | |
| | Physician Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Myou | Carc | lial | Infa | reti | 00 | | | t and Death | |
| | Examiner | Ш | | Due to (or as | a conseque | ence of): | | | | | | | |
| | | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as | a conseque | ence of): | | | | | | | |
| | executed an and rial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | a conseque | ence of: | | | | | _ | | |
| 0 | - (0 = | 1 1 | 3 · · · · · · · · · · · · · · · · · · · | ■ d | | | | | | | | | |
| 68760 | law requires that the death certificate be in as been signed by the attending physicial e. 2 should be detached for use as the bur | Physician/Medica | IF FEMALE: | | | | | | | | | | |
| Box (| ath ce attend | ician | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No | 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy | | | | | | | | Year | |
| - | hat the dea ed by the a detached I | Phys | 9 🗌 Unknown | 9 Unknown | | | | | | | | | |
| s, P.O. | ires that signed d be de | ह्य | Part II. Other significant conditions | contributing to death b | out not resu | ilting in the ur | nderlying cause give | en in Part I. | | | ribute to the caus 3 Probably | | |
| Vital Records, | w require is been si 2 should | Completed | | | | | | | 24a. Was | | Were autopsy find | | |
| Rec | | Som | | | | | | | | psy ormed? | prior to completio death? 1 ☐ Yes 2 ☐ N | n of cause of | |
| ital | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital; | | | 045- | | (Check only one) | | | | |
| 4 | g Physer this | e: To | 1 ☐ Yes 2 No 27. Manner of Death | 28a. Date of inju | iry 2 | ER/Outpatient 28b. Time of | 28c. Injury | _ 4 ∐ Nursi at | ing Home 5 Resi | dence 6 Oth | | | |
| ion | Attending rr death. sctor: After by the fune | Certificate: | 1 Natural 5 Pending 2 Accident Investigativ 3 Suicide 6 Could not | | y, Year) | i n jury | M 1 □ | Yes 2 No | | | | | |
| Division | I or Atten after deat Director: d in by the | | 4 Homicide determined | | ury - At hon c. (Specify) | ne, farm, stre | et, factory, office | | 28f. Location (City or Tov | | er or Rural Route | Number, | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | 29a. Certifier 1 Certifying Ph | ysician: To the best of | my knowle | edge, death o | ocurred at the time | , date and pla | ace, and due to the c | ause(s) and manr | ner as stated. | | |
| | To the H within 24 To the F complete | | | niner: On the basis of e | e best of my | y knowledge, | death occurred at th | e time, date a | and place, and due to | the cause(s) and n | nanner as stated. | | |
| | 7 ≥ 7 8 | | Signature and they beginned | nall D | 7) | | 29c. License | 974 | 18 | 29d. Date signed | d (Month, Day, Yea | ır) | |
| | 101 | | 30. Name and address of person who | completed cause of d | leath (Item 2 | 23a) (Type, Pr | - 4 | . 10 | . 5 | ٠١١٥ | 116 | | |
| | Stat | | 31. Date filed (Month; Day, Year) | empel | 9000 ar's Signatu | | | are D | rive Bal | timors, | MD 2 | 1237 | |
| | Registra | е . | JUI 13 | 2012 | o oigilatu | A K | ake | | | | | | |
| DHN | MH 17 Rev 06-2 | 011 | | 100,00 | | 17 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 10, Day 2012 ear Physician/ 5:30 P_M Dennis Francis Bradshaw Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Parkville 9610 Mason Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours OCT 14 1 X M 2 🗆 F ^{Year)}949 New Jersey 62 Vrs Director 145-40-3651 Usual Residence of Decedent 28a-f show the Maryland items 23a or 28a-f sho her must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 9610 Mason Avenue death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1X Yes 2 \(\sum \) No Black, White, etc. ò þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 l n and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Constellation Energy Control Room Operator the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fil nt of Health and Mental :: If item 27 is marked o ပ Bernice Gilmore Francis Bradshaw traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Bradshaw-spouse 9610 Mason Avenue-Parkville,Maryland 21234 Saltimore, other 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
Dulaney Valley
Memorial Gardens 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important If any injury or once. injury or July 14,2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 15 Fords 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Ph_sician/ disease or condition -16 A Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to or as a conse uence of cause. Enter Underlying Cause (Disease or linjury Exami and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Box 68760 Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 2XNo 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed' death? 1 ☐ Yes 2 ☐ No 2 N Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 00 ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) after death.

Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 🗌 Yes 2 🗆 No 5 Pending injury Accident Investigation upleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hours Funeral cal 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 24 (Check 3 Certifying N within 2 Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Day, Year) 29b. Signature and title 29d. Date signed (Month. 2012 eleted cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G932, 10/1/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month harle Physician Bold /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 0-8-1957 | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) | 9. Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 57 Maryland 54 217-68-0511 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ▼ Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21224 USA 3430 E.Baltimore Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ½
If Yes, Give
Year or Dates: 2 🔀 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Day Care Provider Self Employed 8th grade 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Clara Jeffries Lawrence Bolding 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3430 E.Baltimore St.Baltimore MD.21224 Otto S. Jennings 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery | 07/17/12 | Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore MD.21206 TKL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rears Physician 10 1 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Physician: The law requires that the death certificate be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death Ectopic pregnancy 1 🗌 Live birth Year in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) Yes 2 🗌 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performes 2 No 2 🗌 No 1 🖂 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 3 🗆 DOA 1 SeyYes 2 □ No 2 ER/Outpatient 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death injury 5 Pending investigation 1 Natural or Attending 1 Yes 2 No death. 2 Accident after death Director: / filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00028684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. es3ma 4940 Eastern Avenue, Baltimore, MD, 21224 Edward 31. Date filed (Mouth, Day, Year) State backs

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | | State of Ma | aryland / | / Depa | artment of | Health a | and Mei | ntal Hyg | giene | | | | |
|----------------------------|--|----------------|---|---|---|-------------------|-------------------|--|--|--------------------------------|---|---------------------|--|--|---|-----|
| | | | State Registrar | | | | Cer | tificate of | Death | | | Reg. No. 2012 22 04 | | | | 4 |
| ı | Physicia Medic | | 1. Decedent's Name | | st) | Ba | eck | er-Bo | 1011 | 2. | Date of Dea | Day | Year Y ear | 2 | 3. Time of Death 11:24 ρ Μ | |
| 3 | Examir | | 4a. Facility Name (if n | not institution, give | e street and number) | as p. to | Q | 4b. City, Town, | or Location o | | <u> </u> | | County of De | | | |
| | Funeral Director | | 5. Social Security Nur 215-74- Usual Residence of | mber 6. S 1885 1 | | e (In yrs. last t | oirthday) Yrs. | If Under 1 Yea Months Days | r If Under 2 | 24 Hrs. 8. | Date of Birt (Month, Day Aug | | 1962 | Birthpla Country Mar | ce (State or Foreign yland | |
| | and show 1 at | 5 | | 10b. County | | 10c. City, To | wn or Loc | ation | | | | | | 100 | d. Inside City Limits | ٦ |
| | Maryll 28a-f otifiec | Director | MD | | | Ba. | ltimo | re | | | | | | | 1 Yes 2 No | |
| | with the | Funeral Di | 10e. Street and Numb | ber 28th St. | | | | 10f. Zip Code 212 | | | | | izen of What (| | | |
| 36 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | ρ | 11. Marital Status 1 Never Marrie 3 Widowed 4 | 4 | 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates. | | l II | Vas Decedent of Yes, specify Cul | oan, Mexican, | jin? (Specify , Puerto Rica | Yes or No- an, etc.) | | 14. Race - An Black, Wh Specify: | nite, etc | | 1 |
| Maryland 21215-0036 | 72 hours an "natur Medical I | Completed | (Spec | 15. Decedent's E ify only highest gr | Education 16a (rade completed) | | | | Usual Occupation f work done during most of working T use retired) | | | 16b. Ki | 6b. Kind of Business/Industry | | | 1 |
| 212 | withir giene er th | | Elementary/Secon | idary (U-12) | College (1-4 or 5 | +) | Bar | tender | | | | L | ong Jo | hn' | s Pub | |
| land | i be filed Mental Hy Irked oth tic event | To Be | 17. Father's Name (Fi | rst, Middle, Last) avid Beck | er Jr. | | | | | | irst, Middle, i Eleand | | , | | | |
| , Mary | nd 2 should salth and N n 27 is ma er trauma | | 19a. Informant's Nam | ne/Relationship (7 Miller | | 1 | | g Address (Stree 52 Medf i | | | | - | | | de) | |
| Baltimore, | Page 1 and ment of Hez ant: If item ury or othe | | | | Removal from State | ceme | etery, cren | sition (Name of natory or other pla ake Cren | | | ul 09 012 | 20c. Lo | eltsvi | | n, State Maryland | |
| Balt | permit Depart Import any in | | 21. Signature of Fund | eral Service Licens | see | U0158 | 5 22 | Na Crema E | | | | | | | | |
| | ZD = (0 0) | | 23a Part 1 Enter the | disease or com | plications that caused | the death D | o not onto | | | | | | on Mar | | nd 21286 | |
| P | hy ici n Medical | | shock, or heart Immediate Cause (Fi disease or condition resulting in death) | failure. List only o | ne cause on each line | nonic | ι | The mode of dy | ing, such as c | Sardiac of re- | apriatory and | | | lr C | pproximate nterval Between nset and Death | |
| | Examiner | П | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | ted Insit | aminer | if any, leading to imm cause. Enter Underly Cause (Disease or in | nediate ying | Due to (or as a | consequenc | e of): | | | | | | | | | |
| Ba | ate be executed physician and the burial-transit | dical Examiner | that initiated events resulting in death) La | ast | C. Due to (or as a | consequenc | e of): | | | | | | | | | |
| 376 | ficate g phy: as the | loo i | 1 | | d | | _ | _ | | | | | | | | |
| P.O. Box 687 | to the Mospital or Attending Physician: The law requires that the death certilicate be excluding the death catch death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and the formal director, and the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director. | | IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown | onths? | 23c. If yes, outcome of Live Birth 1 Live Birth 4 Pregnant at 9 Unknown | 2 🗌 Fetal de | | Ectopic pregnal Other (specify) | ncy | | | | 23d. Date of o | delivery Da | | |
| ls, P.O | uires that the dea n signed by the a uid be detached f | ed by Pr | Part II. Other signific | ant conditions o | ontributing to death bu | ıt not resultin | g in the u | nderlying cause o | given in Part I. | | | | | | cause of death? | 1 |
| Division of Vital Records, | sician: The law requires certificate has been sig lirector, page 2 should I | omplet | | | | | | | | | 24a. Was a autop perfor 1 Yes | SV | prior t | o comp | y findings available bletion of cause of | |
| le . | ysician: The la is certificate ha director, page | | 25. Was case referred examiner? | to medical | h — | | | 26. I | Place of Death | h (Check onl | | 2 140 | 1 | 65 2 | | |
| ₹ ; | Physic this ce ral dire | 은 | 1 🗆 Yes 2 🗶 | No | | nt 2 ER/ | | t 3 □ DOA Ot | her: 4 🗌 Nur | rsing Home | 5 Resid | ence 6 | Other (Sp. | ecify) | | |
| on of | ittending P death. stor: After t y the funera | Certificate: | 2 Accident | 5 Pending Investigation | | | o. Time of injury | 28c. Inju wo M 1 | ıryat rk? ∐Yes 2 | | . Describe h | ow injury | occurred | | | |
| Divisi | Hospital or Attending I 24 hours after death. Funeral Director: After stely filled in by the funer | | 3 ☐ Suicide 4 ☐ Homicide | 6 L. Could not b determined | e 28e. Place of Inju building, etc | | farm, stre | et, factory, office | | 28f. | Location (S City or Town | | Number or F | Rural Ro | oute Number, | |
| | To the Hospital or Attending Physikin is defined after the Funeral Director. After this completely filled in by the funeral | Medical | (Check 2 only one) 3 | Medical Exam Certifying Nur | sician: To the best of r iner: On the basis of ex se Practitioner: To the | amination and | d/or invest | igation, in my opir | nion, death occ | curred at the | time, date ar | nd place, | and due to th | e cause | | ed. |
| | vitl To To Con | | 29b. Signature and tit | le of certifier | - N | . D. | | 29c. Licen | se number 24389 | 46 | | 4 | e signed (Mor | | y, Year) | |
| | \ | | 30. Name and addres | s of person who | heen | ath (Item 23a | (Type, P | | | | way | | | | MDZIZI | X |
| | Stat | e | 31. Date filed (Month, | | 22. Registra | - | _ ~ | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 11/1 | - T F | | 112" | | / | . 11/6161 | |
| DIVI | Registra | | 98 | 1 3 2012 | Sendra | 1. | park | | | | | | | | | _ |
| UHM | H 17 Rev 06-2 | :011 | | | | | | | | | | | | | | |

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| | | | For State Registrar | State of Maryla | | artment of H | | | giene 20 | 12 | 22105 |
|----------------------------|--|---------------------|--|---|------------------------------------|---|-----------------------------|-------------------------------|-------------------|--|---|
| A Land | Physici /Medio | | 1. Decedent's Name (First, Middle, Last | im F | Bryo | ant | | 2. Date of Dea Month | Day | Year 2013 | 3. Time of Death |
| | Examir Funeral | ier | 4a. Facility Name (If not institution, give 3018 Reesa 5. Social Security Number 214-54-4718 | 5+. | . last birthday) | 4b. City, Town, or Burney of Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth | 4c. County | 9. Birthpla | ce (State or Foreign |
| | Director | | Usual Residence of Decedent 10a, State 10b. County | | Yrs. | ocation | | Apr 13 | 7, 1930 | | d. Inside City Limits |
| land 21215-0036 | ith the Mar or 28a-f el | Director | MD 10e. Street and Number 3018 Reese St. | В | altimo | 10f. Zip Code 21218 | | | 10g. Citizen of V | | - |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Oepartment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show entry injury or other traumatic event, the Medical Examples multiple at ange. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in I Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates: 1968 | | Was Decedent of Hi If Yes, specify Cuba | | | 14. Race | e - Americar ck, White, etc | n Indian, |
| | within 72 hour ane. then "natural" se Medical Ex | Completed b | 15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12) | ucation | 16a. Dece (Give | dent's Usual Occupa kind of work done of DO NOT use retired Lstered Nu | | ess/Industry | | | |
| | uld be filed v Mental Hygie irked other t itic event, to | To Be Co | 17. Father's Name (First, Middle, Last) William Reddick B | ryant | | | | ne (First, Middle, Lynch | Maiden Sumam | ie) | |
| , Maryland | s 1 and 2 sho if Health and N item 27 ie ma other trauma | | 19a. Informant's Name/Relationship (T) Kim Francis /Ex- | Wife | 301 | ng Address (Street a | t. Balti | more, MD | 21218 | | |
| Baltimore, | t. Pages 1 rtment of He rtent: If iten njury or oth | - | 20a. Method of Disposition Surial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens | Removal from State | cemetery, cre rrison | osition (<i>Name of</i> matory or other place. Forest V | eterans | | | | , Maryland |
| Ba | permi Oepa Impor eny ir | | Rebecca Rec | kermon | 3 | 8717 Green | Pasture | s Drive T | owson Ma | | 21286 |
| | Physician /Medical | | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a conse | Stac | ge C | VA | | | | nterval Between Onset and Death |
| φ. | Examiner hysicien and the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Oue to (or as a conse | | | | | | | |
| 68760, | tificate be ig physicie as the bur | cal | | | | | | | | | |
| P.O. Box | The law requires that the death certifica ate has been signed by the ettending ph bage 2 should be delached for use as it | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 23d. Date of delivery Month Day | | | | | | |
| ords, P | w requires that been signed t should be deta | | Part II. Other significant conditions co | entributing to death but not re | sulting in the u | underlying cause give | en in Part I. | | | ribute to the | cause of death? |
| Division of Vital Records, | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 st | e Completed | 25. Was case referred to medical | | | | as Blace of Do | 24a. Was a autop perfor 1 Yes | med? | Were autops prior to comp death? 1 Yes 2 | sy findings available pletion of cause of |
| Š | Physician: r this certifica rat director, p | To B | examiner? 1 ☐ Yes 2 No | Hospital: 1 🗌 Inpatient 2 🛭 |] ER/Outpatie | nt 3 DOA Oth | ar | lome 5 Resid | | er (Specify) | |
| sion o | Attending Planding Pl | Certification: | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 5 Pending investigation 6 Could not be | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | Work | yat k? Yes 2 ☐ No | | now injury occurr | | |
| DİX | pltai or At urs after d sral Direct | | 4 Homicide determined | building, etc. (Spec | eify) | | | City or Tow | | | |
| | To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I | Medical | 29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Exam 29b. Signature and title of certifier | iner: On the basis of examinand manner stated. | nation and/or in | nvestigation, in my o | pinion, death occi | urred at the time, o | date and place, a | and due to the | he cause(s) |
|) | \\ \\ \\ | | SXC | Amo | | | | Hawk | | | |
| Į, | カ ^{× \} | ite_ | 30. Name and address of person who control of the second o | 32. Registrar's Sign | Y O a C | 15 + Su | iti 3 | Hawk 07, P | ultin | sove | MD 21324 |
| | Registr | ar | JUL 1 3 201 | 4 person | S. pa | Ma | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Barclay Jeffrey 2012 10:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Director 213-66-4220 1 X M 2 🗆 F 57 July 16,1954 Washington DC Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 11700 Old Columbia Pike #101 20904 United States ıral", or items? Examiner mus death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify: "natural", White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. event, the Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and N.

*en 27 is marke
*er traumatic ev ٥ Robert Barclay Ware Kathryn Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger S. Barclay / Brother 675 Kenwood Place, Morgantown, WV Department of Health Important: If item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 07/07/2012 Beltsville, MD Rappe Fundral Fand Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final .Physician/ METASTATIC LUNG CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by PAST OBSTRUCTIVE PNEUMONIA 1 X Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? BIPOLAR DISORDER 24a. Was an this certificate has autopsy performed? 1 □ Yes 2 🔼 No HYPERCALCEMIA 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: $2XX_{No}$ Other: ၉ 1 Yes 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital within 24 hours a Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ire and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D34472 JULY 1, 2012 30. Name and address of person who completed ca death Item 23a) (Type, Print) 10400 CONNECTICUT AVE. #206, KENSINGTON, MD 20895 LYNNE D. DIGGS M.D., 31. Date filed (Month, Day, Year)

JUL 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ju⊓rth Pay 2012 8:10P M Ronald Wayne Brewer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster 301 Klinger Drive If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F 1 0 / 1 9 / 1 9 4 1 70 Director 212-38-4905 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA death with 21157 301 Klinger Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes Yes, Give 2 No 1961-72 hours after Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Sales Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kathryn Thomas Guy Leroy Brewer Sr. . Page 1 and 2 should ment of Health and N ant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 301 Klinger Dr., Westminster, MD 21157 Lynette Brewer-wife Saltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₫ = 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once, Westminster, Maryland 7/17/2012 Westminster Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E Main St. Westminster, MD 21157 21. Signature of Pyperal Service Licensee St., Westminster, MD 254 Ε. Main 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shows a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a con uence of): Due to **Examiner** Sequentially list conditions. if any, leading to immediate dauge. Enter Ordenying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) signed by the a 1 Yes 2 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director; After this certificate h 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, Be 26. Place of Death (Check only one) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Levertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

1 3 2012

er St

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tu 2017 Medical 4a. Facility Name (if not institution, give street and number **Examiner** County of Death Hospita If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Director 1078 1 M 2 F MY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show filed within 72 hours after death with the Maryland at Hygiene. 10a. State 10b. County 10c. City, any injury or other traumatic event, the Medical Examiner must be notified at Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. þ 1 Never Mamed 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 ☐ Widowed 4 ☐ Divorced Yes, Give Blac Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO_NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry U. N.K. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be ၉ 19a. Informant's Name/Relationship (Type, 20a. Method of Disposition 20b. Place of Disposition (Name of remetery_crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 728 23a. Part 1. Ends the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ohogestine disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year been signed by the a should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2. No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manufel of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Division 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) mi lesace 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh, g929 7-19-12 sm. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ ₩M Richard F. Rowen Sr. July 2012 Medical 3 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8550 Beacon Point Rd <u>Pasadena</u> Anne Arundel 8. Date of Birth (Month, Day Year If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Maryland 1 🛛 M 2 🗆 F Months Hours Min Yrs. 75 **Director** 212-32-8663 Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at the Maryland Funeral Director notified 1 Yes 2 No Maryland Anne Arundel Baltimore 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? ò must be n 7930 Main Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iten Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Glazer Glass 6 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leslie Bowen Thelma Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31950 Two Ponds Rd., Selbyville, DE 19975 Donna Szuba – daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date cemetery, crematory or other place) Lorraine Park Cem July 17,2012 Baltimore, MD Donation 5 Other (Specify) f Funeral Service Ace 22, Name and Address of Facility 21. Sign Stallings Funeral Home, PA , Pasadena. 3111 Mountain Rd. MD 21122 23a. Part 1. Enter the disease, or comp shock, or heart failule. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final chema Messen Phylician/ disease or condition Medical resulting in death) **Examiner** Altero Scheros No Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ evonero HYLEYU 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 certificate 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Veilla Her Other: 4 Nursing Home 5 Residence 1 Yes 2 10 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of A ath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Latural 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #608 1600 GLRN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day Physician/ July 20ÎŽ 5:39 рм Eugene John Berge Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 214-24-8231 1 ☑ M 2 ☐ F 85 1926 8, Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy living or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Abingdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21009 USA 703 Long Bar Harbor Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Year or Dates Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Chief Oil Engineer Petroleum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Katherine Ledig Andrew (nmn) Berge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Long Bar Harbor Rd., Abingdon, MD 21009 Marie Berge / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State **∞** 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 7-11-12 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed by the burst after death.

Funeral Director: After this certificate has been signed by the attending physician and eterly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy EUGENE BERGE in the past 12 months? Month 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 🔀 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Yard) 2 32. Registrar Signature State JUL Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ (Menth 2 ở⁴r2 0^{23} 9:55A M Joseph Butler Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 640 N. Avondale Rd. Baltimore 5. Social Security Number 5 7 9 – 2 6 – 3 5 7 8 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) Davs Hours Director 1 XM 2 □ F Yrs Washington DC 85 10/08/1926 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Dundalk. Baltimore Co. 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 640 N. Avondale Rd. 21222 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☒ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) years 4 Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Mack Joseph Butler Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 N. Avondale Rd., Baltimore, MD 21222 Derrick Colvin(son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Baltimore Nat'L 07/10/12 Baltimore, 4 ☐ Ponation 5 ☐ Other (Specify) Synature A Funeral Service Lice 2505e514dr F. of FB Frown Jr. Funeral Home PA Baltimore, 2140 N. Fulton Ave., MD21217 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death cloilit Physic and disease or condition reers Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 1 Yes 2 g Unknown 2 No q 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart failure, 1 Yes 2 No 3 Probably 4 Unknown Completed NITAGE CANCER, anemia of cironic discusse 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DANo Hospital မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST NES (5101 31. Date filed (Month, Day, Year) 2012 Registrar

DHMH 17 Rev 06-2011

Alfredo Rudriques 12-05139 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month D July 8, 2012 Medical Examiner 1813 hrs Jose Alfredo Rodriguez Carvajal 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death 1600 South Eutaw Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Min Director 35 Sep. 28, 1976 Country) Mexico 1 XM 2 F None Yrs Usual Residence of Deceden 10a, State 10c City Town or Location 10d Inside City Limits 10b County 1 X Yes 2 No MD Baltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 South Eutaw Street 21201 Mexico Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 3 Widowed If Yes, Give Year 1 X Yes 2 No specify: Mexican White 4 Divorced Specify: Ď or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " Baltimore, MD 21215-0036 Dry Wall Installer 8 Construction iment of Health and Mental Hygiene.

Tant: If item 27 is marked other the 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Valentin Rodriguez Jovita Carvaja1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silvia Rodriguez - Sister 2215 E 51st Street, A 05, Austin, TX 78723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 7-19-2012 Rio Verde, SLP, MX 4 Donation 5 Other Specify. E1 Moral Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 22310 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Madical Death a. Gastro-intestinal Bleeding Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Rupture Esophageal Varices Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause c. Cirrhosis of Liver (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last d. Chronic Alcoholism hysician/Medical ysician a UNPENDED AMENDED Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery signed by the attending phy: be detached for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page certificate Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification thin 24 hours after death.

o the Funeral Director: A Division 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 9, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day Year)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OS) Physician/ Brian Anthony Cook 4:05 pm 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3808 Byfield Road Baltimore Lochern 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral Days Hours Country) 215-04-5065 35 Director 06/15/1977 Maryland Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10b. County at Director Examiner must be notified Maryland Baltimore Lochern 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23a Funeral 21207 3808 Byfield Road USA items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 Divorced Completed item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within intent of Health and Mental Hygiene. ant: If item 27 is marked other than Unemployed vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles McKennley Cook Nena R.Linton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3808 Byfield Road Lochern, Maryland 21207 Nena Roberson/Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland 07/13/12 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore MD. 21215 Signature of Furjeral Service Licerse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ INFARCTION HOUTE Mynorthon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No signed by the a ld be detached f g Unknown ☐ Yes ∠ _ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBN 515 1 Yes 2 No 3 Probably 4 Y Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital ျှ 1 🗌 Yes 2 🛱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 K Natural 5 Pending injury 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical 星 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **TDletely** (Check 3 🗆 the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) Signature and title o 30408 d address of person who completed cause of death (Item 23a) (Type, Print) 30 Name a

DHMH 17 Rev 06-2011

State Registrar JAO MAZHINITA

sistrar's Signature

waron

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical if not institution, give street and number) or Location of Death County of Death **Examiner** hearn 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under If Under 24 Hrs. **Funeral** Vearl Country) 1 🗆 M 2 🗶 F Director 60 10/26/1951 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 X Yes 2 No MD Himore 10e. Street and Number 10g. Citizen of What Country? Funeral Scton 21215 USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc 1 Never Married 2 Married þ 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during life. DO NOT use retired)

Muil Carrie Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien Be 17. Father's Name (First, Middle, Last, 18 Mother's Name (First, Middle, Maiden Surname) Department of Health and Department of Health and Menta Important: If item 27 is marked any injury or other traumering. ပ Cousins ce Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) St. Baltimore, MD Kona Kelly 2023 N. Wolfe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) ansdown, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licenses €. North Baltimor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ 6 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) -transit that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician a d be detached for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No page 2 Director: After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) work? 5 Pending 2 No М Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 2100 30. Name and decress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

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| | • | For State Registrar | State of M | aryland / L | Certifica: | III OI I | icaitii ana i | vieritai i iy | Reg. No. | 2012 | 22115 |
| Physicia | | Decedent's Name (First, Middle, La | st) | 0 11 | Λ - | | | 2. Date of De | | Year | 3. Time of Death |
| Medi | cal | 4a. Facility Name (if not institution, give | e street and number) | Call | ender 14h Cith | Town or | r Location of Death | JULY 5 | 4c. (| 2012 County of Death | 20:35 M |
| Exami | ier | SINAI HOSPITAL | | IMORE | | | LORE C | city. | | | |
| Funeral Director | | Social Security Number 6. S | Sex 7. Ag | je (In yrs. last birt 62 | hday) If Undo Months Yrs. | Days | If Under 24 Hrs. Hours Min. | 8. Date of Bii (Month Da Mar | rth ay 2^{V9}a r) | 1950 Cou | nplace (State or Foreign intry) |
| and show | 힏 | 10a. State 10b. County | | 10c. City, Towr | or Location | | | | | | 10d. Inside City Limits |
| he Maryland or 28a-f show | Director | MD | | Bal | rimore | | | | | | 1 X Yes 2 □ No |
| ith the | | 10e. Street and Number 1810 Ruxton Ave | <u>.</u> | | 101.2 | ip Code 2121 | .6 | | | zen of What Coo nited S | |
| eath w | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | 13. Was Dece | dent of H | lispanic Origin? (Sp an, Mexican, Puerto | pecify Yes or No | . 1 | 4. Race - Amer | |
| 36 36 after d | िह | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Tes 2 K | | 1 Yes | | | Thoun, olon | 3 | Black, White Specify: | Black |
| nd 21215-0036 If 21215-0036 If the Maryland all Hygiene. If the Medical Examiner must be notified at went, the Medical Examiner must be notified at which we were the medical Examiner must be notified at which we were the medical examiner must be notified at which we were the medical examiner must be notified at which we were the medical examiner must be notified at which we were the medical examiner must be notified at which we were the medical examiner when we were the weak when we were the medical examiner when we were the weak when we were well as the weak when we will also well as the weak when we were well as the weak whe | Completed | 15. Decedent's I | | 16a. | Decedent's Us | ual Occup | pation | | 16b. Kir | nd of Business/I | ndustry |
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| d 21 d 21 led with Hygien other the | ادها | 17. Father's Name (First, Middle, Last) | | | Custoa | Lan | 18. Mother's Nar | ne (First, Middle | Ь | | 111101101 |
| I be file fental larked o | 일 | | llender | | | | 1 | Griffit | | , | |
| NOTION AS CALEINIES, CERTINAL INC., CERTINAL INC., MARKET AND SOLUTION AS 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at | | 19a. Informant's Name/Relationship (Neil Marshall | | 195 | | | and Number or Ru ew Dr. Sp | | | | |
| Baltimore, Baltimore, bermit. Page 1 and Department of Hec Important: If item any injury or othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [| Removal from State | e cemete | f Disposition (Na ry, crematory or | other plac | • | Date Jul 13 | 1, | cation - City or | Town, State |
| | | 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer | eify) | Ches | apeake | | atory son and Fu | 2012 | | | e, naryrana |
| Balti Balti permit. Departr Imports any inji | | Roberta A | achein | uois85 Von | | | | | | | land 21286 |
| | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only | nplications that cause one cause on each lir | d the death. Do r | not enter the mo | de of dyin | ng, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between |
| Physician Medical | 1 | Immediate Cause (Final disease or condition resulting in death) | a. ASPIR | ATION | PRIE | UMO | NIA | | | | Onset and Death DAYS |
| Examiner | | | Due to (or as | a consequence | 01): | | | 1 | ٠. | | |
| E E ALE | iner | Sequentially list conditions, if my leading immediate cause. Enter Underlying | b. Due to or as | a consequence | of): | | 0: | TO BY | MEDICAL EX | AMINER | |
| 3760 & ficate be executed g physician and as the burial-transit | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | a consequence | of): | | CERTIFICAT | ION APPROVED BY | | | |
| 760 cate be exemply side of the purial | 1-1 | Toolising in dodsity and | d | | | | | | | | |
| 876(ifficate og phy as the | Medi | IF FEMALE: | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be with 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicial mpletely filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medica | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 2 Fetal deat at time of death | h 3 🗌 Ectopio 5 🗍 Other (| | су | | | 23d. Date of del Month | ivery Day Year |
| P.O. that the med by the detach | by Ph | Part II. Other significant conditions | contributing to death | but not resulting | in the underlying | g cause gi | iven in Part I. | 23e. Did | tobacco u | se contribute to | the cause of death? |
| ital Records, P.(sician: The law requires that certificate has been signed rector, page 2 should be de | ted t | ANOXIC BRA | M M | URY | : | | | 1 🗆 | Yes 2 [| I2No 3□P | robably 4 🗌 Unknown |
| COr law ren nas be e 2 sh | Completed | | TER | | | | | 24a. Wa aut | s an opsy formed? | 24b. Were au prior to death? | topsy findings available completion of cause of |
| Refracte Programmer, page | | 25. Was case referred to medical | FAILURE | | | 26 8 | Place of Death (Che | 1 🗆 Yes | 2 No | | 2 12 No |
| Vita ysicia s certi directe | To Be | examiner? 1 Ves 2 No | Hospital: | tient 2 ER/O | utpatient 3 🗆 | Oth | ner: | Home 5 \square Res | sidence 6 | Other (Spec | ify) |
| Division of Vital Records, tal or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a second to the funeral director. | | 27. Manner of Death 1 1 Natural 5 Pending | 28a. Date of in (Month, D | ury 28b. | Time of injury | 28c. Inju | k? | 28d. Describe | how injury | occurred | |
| Sion of Attending P r death. sctor: After t | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not | be 280 Place of Ir | ijury - At home, fa | M arm street facto | | Yes 2 No | 28f Location | (Street and | Number or Ru | ral Route Number, |
| Divis al or A safter I Direct | | 4 Homicide determined | building, e | tc. (Specify) | arri, otroot, ract | ,, 011100 | | | own, State) | | |
| Division of Vital I To the Hospital or Attending Physician: I within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, | Medical | (Check 2 Medical Evan | ysician: To the best on niner: On the basis of arse Practitioner: To t | examination and/ | or investigation, i | n my opini | ion, death occurred | at the time, date | and place. | and due to the | cause(s) and manner stated. |
| To the within To the сопр | 2 | 29b. Signature and title of certifier | | | | 9c. Licens | se number | | | e signed (Montl | |
| | | PATRICIA T | ELLEZ h | ATSON | MD | RES | - 000 | | JUL | y 05 | 2012 |
| 5 | | 30. Name and address of person who PATRICIA TE | completed cause of | death (Item 23a) | (Type, Print) | | SINIAI | HOST | PITA) | OF | BALTIMORE. |
| | ate | 31. Date filed (Month, Day, Year) | | rar's Signature | ba Val | | | 1 10001 | 12 | | |
| Regist | ar | ■ .HH 1.3 ZUI | 6 / Ye - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 1 | 1 13. 16 | www | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| ucille (| Jiark | | 1-For State Registrar State of Maryland / Department of Health and Mental Certificate of Death | | g. No. | 2 221 |
|---|---|----------------|--|---|---|--|
| nysiciar | n/ Medi Exami | cal | 1. Decedent's Name (First, Middle,Last) | Date of Death Month | n Day Year | 3. Time of Death |
| Sales Commencer | EXAIII | ii lei | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De | July 5, 201 | 2 4c. County of Deat | 0030 hrs |
| | | | 1643 Cliftview Avenue Baltimore | | N/A | |
| | ineral rector | | 1 M 2 AF 6.3 Yrs. | 8. Date of Birt Min 12/5/ | C | rthplace (State or Foreign buntry) MD |
| | any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| and | 28a-f show any d at once. | ъ | MD N/A Baltimore | | | 1 Yes 2 No |
| the Maryl | Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Executar must be norfiled at once. | Director | 10e. Street and Number 1643 Cliftview Ave. 10f. Zip Code 21213 | 10 | g. Citizen of What Cou USA | ntry? |
| ath with | tems 2 | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexicen, Pu | | 14. Rece - Amer White, etc. | ican Indian, Black, |
| after de | u", or i | | 1 Yes 2 No 3 Widowed 4 Divorced by Yes, 6 Ne Year In Dates 1 Yes 2 No 1 Yes 2 No specify: | | Specify: Bla | ack |
| hours | Power | ed b | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use | of work done retired) | 16b. Kind of Business/I Hadwi | |
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| Baltimore, MD 21215-0036 oemit. Pages 1 and 2 should be filed within 7 | ntal Hygie rk ed other ent, the N | Be Cor | 17. Father's Name (First, Middle, Last) Haywood Clark Janio | e Clark | | |
| MD 21 | th and Me 127 is ma umatic ev | 70 | 19a. Informant's Name/Relationship (Type, Pnnt) Kandice Richardson-Niece 19b. Mailing Address (Street and Number 127 Christine Dr | | er, City or Town, State, Sville, | |
| ore, | of Heal If iten her tra | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or | |
| Itimo | rtment ortant: ry or ot | | 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | | Randall: /H- East | stown, MD |
| Ba | Depz Imp inju | | 2 Munton 1101 E. North | | | MD 21202 |
| | sician edical | | 23a. Păft I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. | or respiratory arrest | , shock, or heart | Approximate Interval Between Onset and Death |
| Exa | miner | | Immediate Cause (Final disease or condition resulting in death) a exsanguination Due to (or as a consequence of): | | | Ceaul |
| | | ы | Sequentielly list conditions, if any, leading to immediate be breakdown of vascular shunt for endstage renal disease Due to (or as a consequence of): | | | |
| | | Examine | cause. Enter Underlying Cause (Disease or injury that initiated | | | |
| cuted | nd transit | | events resulting in death) Last | | | |
| O, | g physician and the burial - transit | /Medical | UNPENDED AMENDED | | | |
| 8760 , rlificate be | ing phy as the | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre | gnency | 23d. Date of delivery Month | oay Year |
| Box 68 | y the attending hed for use as t | Physician | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | | | |
| Division of Vital Records, P.O. | e has been signed by t | è | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tob | ecco use contribute to t | he cause of death? ebly 4 Unknown |
| rds, | s been s should b | Completed | | 24a. Was ar autops | | topsy findings available completion of cause of |
| Reco The law | cate ha | E G | | perform | ned? death? XNo 1 Ye | - |
| ital F | s certificate l rector, page | Be | 25. Wes case referred to medical examiner? Hospitel: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Num | | | |
| of V | After this funeral dir | 2 | 27, Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | 28d. Describe ho | Residence 6 X Other ow injury occurred | Scene |
| Sion | deam. ctor: A y the fu | ation | 1 Natural 5 Pending FOWND Day, Year) 2 Accident Investigation Jul 4 2012 FOWND: 1 Yes 2 No | | f vascular shunt | |
| Division of Vital Records, P.O. Box 68760, | Within 24 hours after death To the Funeral Director: completely filled in by the | Certification: | 3 Surcide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Townhouse / Rowhouse | 28f. Location (State or Town, State UNKNOWN | reet and Number or Rur ate) | al Route Number, City |
| o the Ho | o the Fur | ca | 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, an one) 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred and manner stated | | | ause(s) |
| | ≱ H ŏ | Med | 29b. Signature and title of certifier 29c, License number | | 29d. Date signed (Mor | nth, Dey, Year) |
| PH | M | | 30 Name and address of person who completed cause of death (Item 23a) | CME | July 5, 2012 | |
| . / | 11' | | Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B | Baltimore, MD 21 | 223 | |
| | St Regist | ate rar | 31 Date filed (Month, Day Year) 13 2012 32 Registrer's Signature | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Christopher David Clark 07/07 2012 18:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Hours 073-58-8449 Director 1**X** M 2 □ F 47 June 11, 1965 New York Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 21017 USA 4409 Tolchester Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Poppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event exercises." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Computer Programming Game Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joan Frances Williams Carlton Leon Clark Cler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 4409 Tolchester Court, Belcamp, Maryland 21017 Karen Hamilton Clark / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Churchville, Maryland 7/14/2012 Watters Cemetery 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License Styler 1317 Cokesbury Road, Abingdon, Maryland 21009 De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hours Immediate Cause (Final Physician/ Pulmonary embolism disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 No Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No the f Accident Suicide Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) earline D30206 07/10/12 pleted cause of death (Item 23a) (Type, Print) - GBMC 6701 Charles Street, Baltimore MD Steven H. Pearlman M.D. N. 31. Date filed (Month, Day, Year) **JUL 1 3 2012** 32. Registraris Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06:56 PM CHARLES, CACACE 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. 055-18-5468 **Director** 1**X**XM 2 □ F Yrs. New York 10-15-1922 89 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ms 23a or 28a-f sho must be notified at Director MD Anne Arundel Pasadena 1 Yes 2XXNo 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral United States 844 Swift Road 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status r than "natural", or iter the Medical Examiner Armed Forces? 1 X Yes 2 No 1942-Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Health 5+ Social Worker ath and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patsy Cacace Josephine Mole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 844 Swift Road, Pasadena, Maryland 21122 Judith Cacace - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 07-09-2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Rome at 21. Signature of Funeral Service L MMP, Inc, 7250 Wash. Blvd, Elkridge, MD 21075 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PULMONARY EDEMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC KIDNEY DISEASE unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) OBSTRUCTIVE PULMONARY DISEASE UNKNOWN Exami CHRONIC Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) UNKNOWN Physician/Medical CORONARY ARTERY DISEASE Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the al detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SPINAL STENOSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D72410 07/06/2012 - Kuwana Vuga 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 3001 S. HANOVER ST LUCIANA VEIGA 31. Date filed (Month, Day, Year) -State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15AM Nancy 2012 14 100 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Pasadena 642 Cedar Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-72-6688 (Month, Day, Year) Director 1 □ M 2 □ F 56 Yrs June 15, 1956 Maryland Usual Residence of Deceder or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pasadena Anne Arundel 1 Yes 2 w No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21122 USA Funeral 642 Cedar Lane death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 5+^{College (1-4 or 5+)} life. DO NOT use retired) Elementary/Secondary (0-12) Health Care Medical Social Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Susannah McLane Paul L. Boch ge 1 and 2 should be nt of Health and Men t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Ciulla - Husband 642 Cedar Lane, Pasadena, Maryland 21122 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State meadowridge Mem. Park Injury or 07/14/2012 Elkridge, Maryland Department Important: It any Injury or once. 4 Donation 5 Other (Specify) Gary L. Kaufman F.H. @ MMD 22. Name and Address of Facility 21. Signature of Puneral Service Licens MO1283 7250 Washington Blvd., Elkridge, Maryland 21075 or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Erver the disease, shock, or heart failure. Lis-Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to (or as a consequence or): Exami attending physician and I for use as the burial-transii Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the a should be detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has page 2 ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours . To the Funeral L Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioners To the best of my knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 LO Date filed (Month Year) State

DHMH 17 Rev 06-2011

Registrar

Burma craig

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|------------|--|-------------------|--|----------------------------------|---|----------|-----------------------|--------------------------------|------------------------|---------------------------|--------------------------|------------------------|---------------------------------|-------------------|--------------|------------------------|---------------------|------------------------|
| | | | For State Registrar | | State | ot Ma | arylan | | | nt of H | | and M | 1ental Hy | _ | 2 | n I | 2 2 | 212 |
| | | | 1. Decedent's Na | me (First, Middle, | Last) | | | | | 0.5 | - Cuti- | | 2. Date of De | Reg. N | 0. | U L | 3. Time | e of Death |
| | Physicia Medi | | Buirma A | . Craig | | | | | | | | | Month 7 | g | ay a | Year | 5: | 00 PM |
| | Examir | | | | give street and nur | | | | _ ` | - 6 | Location | of Death | | | c. County | 2 | | |
| معديب | Funeral | | 5. Social Security | n Sque | are Hos | 7. Age | fallo vrs. la | ast birthday) | | 5 <u>C</u> Cor 1 Year | If Under | 24 Hrs. | 8. Date of Bir | | 30-1 | | | te or Foreign |
| | Director | | 219-38-029 | | 1 □ M 2 🏋 F | | 74 | Yrs. | Months | Days | Hours | Min. | 12/16/ | | | Cour | ntry) | 2 3 7 3 3 3 g |
| | d ow t | | Usual Residence | | | <u> </u> | 10o City | y, Town or Lo | nation | | | | | | | | _ | City Limits |
| | arylan a-f sh fied a | ecto | MD | Baltimor | ~ | | | ttinghan | | | | | | | | | | Yes 2 No |
| | or 28 | ğ | 10e. Street and N | | re | | 140 | rmaa | _ | p Code | | | | 10g. C | Citizen of V | Vhat Cou | ntry? | |
| | ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Funeral Director | 8705 Bla | irwood Ro | ad | | | | | 21236 | 5 | | | | USA | | | |
| | r item iner n | | 11. Marital Status | arried 2 Marri | 12. Was Dec Armed Fo ed 1 \(\sum \) Yes | edent E | ver in U.S | 3. \ 13. \ | Vas Dece f Yes, spe | dent of His cify Cubar | spanic Ori n, Mexicar | gin? (Spe 1, Puerto | cify Yes or No- Rican, etc.) | | | e - Ameri k, White, | can Indian, etc. | |
| 036 | s after 'al", o Exam | d by | | arried 2 L Marri 4 L Divorced | ed 1 L Yes If Yes, Gi Year or D | ve | No | | □ Yes | 2 X No | Specify: | | | | Specify: | Africa | an Amei | rican |
| 215-0036 | hour fnatur dical | Completed | /Si | 15. Deceden | | | | 16a. Deced | | | ation Juring mos | t of worki | na | 16b. | Kind of Bu | | | |
| 121 | thin 72 ne. than the ne | lmo | Elementary/Se | | College (| | +) | life. D | O NOT us | e retired) | amig mos | CO WOIN | ·ig | | | | | |
| d 21 | ed wil Hygie other ent, th | Be C | 17. Father's Name | e (First, Middle, La | 1 3 | | | l Han | ne Mak | er | 18. Moth | er's Name | e (First, Middle | | Home N | | | |
| lan | l be fil fental rked tic ev | 은 | Benjami | n Edmonds | | | | | | | | | Sannervi | | | , | | |
| Maryland | should and M is ma | | 19a. Informant's | | ip (Type, Print) | | | 19b. Mailir | ng Addres | s (Street a | | | l Route Numbe | | or Town, S | tate, Zip | Code) | |
| 2 | and 2 s Health tem 27 | | | Moore / Da | aughter | | | | | | cle P | | lle, Mary | | | | | |
| Baltimore, | Page 1 annent of Hant of Hant If ite | | | 2 Cremation | 3 Removal from | n State | C | lace of Dispo emetery, cren | natory or | other place | | | Date | 1 | | | own, State | |
| Itim | permit. Page Department o Important: If any injury or once. | | 4 L Donatio | n 5 Other (S) | | | Kir | ng Memor | ial F | ark | s of Facil | 7/19 Wlie | 9/2012 Funeral | l Bal Home | timore | of H | land | 20 |
| Ba | permit. Departr Imports any inju | 10 | | u n V | 1(6 | Q | | | | | | | lstown, | | | | 10. | |
| | | | | | complications that | | | n. Do not ente | er the mod | de of dying | g, such as | cardiac c | r respiratory a | rrest, | | | Approxir | mate Between |
| marie. | Physician/ | 8 8 | Immediate Cause disease or condi | e (Final tion | • | - 0 | | nic 4 | Sho | rk | | | | | | | | nd Death |
| hage | Medical Examiner | | resulting in death | 1) | Due to | (or as a | con equ | ience of): | | 7 | eranar. | | | | | | | |
| 25 | | ē | Sequentially list | conditions, | b. 5 y 5 | tar | MIC. | A m | ylor | 105 | 5 | | | | | - | | |
| | nted d ansit | Examiner | cause. Enter Und Cause (Disease of | or injury | mul | tic | 10 | Mye | lan | 20 | | | | | | | | |
| | e executed ian and urial-transit | | that initiated eve resulting in death | | Due to | (or as a | consequ | ience of): | + | - | | | | | | | | |
| 9 | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2. | Physician/Medical | | ' | d | | | | | | | | | | | | | |
| 68760 | ertifica Iding p | /Me | IF FEMALE: 23b. Was decede | nt pregnant | 23c. If yes, ou | | | | | | | | | | 23d Dat | e of deliv | /en/ | |
| Вох | eath c atter d for u | iciai | in the past 1. | 2 months? | 4 Preg | gnant at | 2 ∐ Feta time of d | I death 3 L leath 5 L | Ectopic Other (s | | У | | | | Mo | | Day | Year |
| P.O. E | t the d by the | Phys | 9 🗌 Unknov | | 9 🗌 Unk | | | | | | | | <u> </u> | i | | | | |
| <u>o</u> . | ss that igned be de | | 1 | 4 | enal T | | | _ | nderlying | cause giv | en in Part | 1. | | | _ | | he cause o | of death? ☐ Unknown |
| rds | requir | etec | L110 J | ragen | chort (| בוק | 243 | 2 | | | | | 24a. Was | | | | | gs available |
| Records, | e law e has l | Completed by | | | | | | | | | | | auto | psy ormed? | _ F | rior to co leath? | ompletion of | of cause of |
| <u>E</u> | an: Th tificate tor, pa | | 25. Was case refe | rred to medical | | | | | | 26. Pla | ace of Dea | th (Check | | 2 | No. 1 | ☐ Yes | 2 No | |
| of Vital | nysici nis cer I direc | o B B | examiner? | No No | Hospital: | Inpatie | ent 2 🗆 | ER/Outpatier | nt 3 🗆 🗆 | Othe | er: 4 🗆 Ni | ursing Ho | me 5 🗆 Resi | idence | 6 🗌 Othe | r (Specif | y) | |
| 1 of | ing Ph After th uneral | | 27. Manner of De | ath 5 🗌 Pending | 28a. Date (Mor | of injur | | 28b. Time of injury | | 28c. Injury work | ? | | 28d. Describe | how i nj u | iry occurre | ed | | |
| Sior | death ctor: A y the f | Certificate: | 2 Accident 3 Suicide | Investig | ation not be | of Iniu | n/ - At ho | me, farm, stre | M And Andrew | | Yes 2 | | 28f. Location (| Stroot | nd Numbe | r or Rura | I Route Nu | ımher |
| Division | al or A after Direct | | 4 L Homicide | e determi | | | . (Specify) | | set, ideter | y, omoc | | | City or To | | | or ritire | a riodio ivo | Thio Gi, |
| | ospita hours uneral | Medical | 29a. Certifier | | Physician: To the | | | | | | | | | | | | | manner stated |
| | the H hin 24 the Fi | Me | (Check only one) | 3 Certifying | kaminer: On the ba Nurse Practitione | | | | death oc | curred at th | ne time, da | | | the caus | se(s) and m | nanner as | stated. | |
| | vit To | | 29b. Signature an | d title of certifier | | | _ | | | c. License | | 21 | | _ | | | Day, Year) | |
| | | | 30 Name and ad | dress of norman | who completed cau | se of do | eath (Item | _ | | 00 د | 631 | , 6 | | / | -9- | 90 | 10 | |
| | | | | | | | | | | ank/i | n Sai | 10150 | Drille | Bal | timo | Se . N | D 2 | 1237 |
| | Sta | | 31. Date filed (Mo | nth, Day, Year) | 2 Noach | Registra | r's Sionat | ture | 1 | | | , -, - | | | | | | |
| | Registr | ar | 30 | L 1 3 COI | c france | | p. | 7 | _ | | | | | | | | | |

DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hygiene

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|---|---|---|---|---|---|--|

| · · | | 1- For State C6 | ertificate of | Death | | Reg | J. No. | 12 22 12 |
|---|---------------|---|--|--------------------|---|------------------------------|---------------------------------------|--|
| Physici | an/ | Decedent's Name (First, Middle, Last) | | | | Date of Death Month | Day Year | 3. Time of Death 2336 hrs |
| Medical Exami | | Alec John Cosgarea 4a. Facility Name (if not institution, give street and number) | - 4 | h City Town o | r Location of Death | July 9, 201 | 2 4c. County of Death | |
| | | University Hospital | | Baltimore | | | N/A | |
| Funeral Director | | 5. Social Security Number 275–98–9565 300–98–8794 1 M 2 F | . last birthday) 17 Yrs. | If Under 1 Yes | | | (MM/DD/YYYY) 9. Bir Foreig | |
| any | ŀ | Usual Residence of Decedent 10a. State 10b. County 10c. City | ty, Town or Location | on | | | | 10d. Inside City Limits |
| * . | _ | Maryland Baltimore Ow | wings Mil | 11s | | | | 1 Yes 2 XX No |
| faryla 28a-f | | 10e. Street and Number | | 10f. Zip Code | | 10 | g. Citizen of What Cou | ntry? |
| with the Maryland ms 23a or 28a-f show be notified at once. | | 3 Alterwood Lane | | 21117 | | | J.S.A. | |
| 0036 within 72 hours after death with the Maryland joine. her than "natural", nr items 23a or 28a-f she Medikal Examiner must be notified at once | Funeral | 11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No | If Ye | es, specify Cuba | spanic Origin? (Sp n, Mexican, Puerto | | White, etc. | can Indian, Black, |
| s after iral", | ò | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) | | Yes 2 No | specify: | work done | Specify: NIII | |
| 2 hour | sted | Elementary/Secondary (0-12) College (1-4 or 5+) | | | e. DO NOT use reti | | Education | , radou y |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours at ment of Realth and Mental Hygiene. tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin | Completed | 11 | Stud | dent | | | | |
| 15-0 filed w d Hygi ed othe | Be Co | 17. Father's Name (First, Middle, Last) Andrew Cosgarea | | | 18.Mother's Name | (First, Middle, M Sulliva | | |
| 212 Muld be Menta mark | | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | Address (Stre | et and Number or F | Rural Route Numb | per, City or Town, State | , Zip Code) |
| MD d 2 shc lth and n 27 is numati | | Andrew Cosgarea / Father | 3 A1 | terwood | Lane Ow | ings Mi | lls, MD 21 | 117 |
| or Heal | | 1 Removal from State | Place of Disposit crematory or other | er place) | | | 20c. Location - City or | · · |
| Baltimore, permit. Pages 1 a Department of He Important: If ite | | 4 Donation 5 Other Specify: | ulaney Va | | | | Timonium, | The second second |
| Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury nr nther traun | _ | 21. Signature of Funeral Service Licensee | 10! | ame and Addres | Road To | wson, Ma | on Funeral aryland 212 | .04 |
| Physician Medical | | Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line. | th. Do not enter the | e mode of dying | , such as cardiac o | r respiratory arres | st, snock, or neart | Approximate Interval Between Onset and Death |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence | of): | | | | | 2000 |
| | | Sequentially list conditions, b | | | | | | |
| | nine | if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause | of): | | | | | |
| ed sit | Examiner | (Disease or in jury that infilated events resulting in death) Last Due to (or as a consequence | of): | | | | | |
| 760, icate be executed physician and the burial - transit | | d. UNPENDED AMENDED | | | <u> </u> | | | |
| '60, ate be ohysicia | Medical | IF FEMALE: 23c. If yes, outcome of pre | egnancy | | | | 23d, Date of deliver | , |
| 687 certific nding p | | 23b. Was decedent pregnant in the past 12 months? | dooth - | | Ectopic pregna | ancy | Month I | Day Year |
| Box 687 The death certification is the attending of the attending of the set | Physician | 1 Yes 2 No 9 Unknown 9 Unknown | death 5 Oth | er (Specify) | | | | |
| F. 4 F. 8 | by Ph | Part II. Other significant conditions contributing to death but not | resulting in the un | nderlying cause | given in Part I. | | acco use contribute to | |
| S, P.C luires that an signed to | ed b | | | | | 1 Yes | 2 No 3 Proi | topsy findings available |
| cords aw requi has been 2 should | Completed | | | | | autops perform | y prior to | completion of cause of |
| tal Reco | 20 | | | 00 Bl- | - of Death (Obselv | 1 ✓ Yes 2 | | es 2 No |
| Vital ysician: his certifi director, | Be | 25. Was case referred to medical examiner? Hospital: Inpatient 2 | ✓ ER/Outpatient | | of Death (Check | | tesidence 6 Othe | |
| of Vision Physical After this funeral dir | 6 | 1 Ves 2 No 28a. Date of Injury | 28b. Time of In | jury 28c. Inju | ury at Work? | | ow injury occurred lost control and s | truck a tree |
| ion ttendii leath. tor: / | aţio | 1 Natural 5 Pending Jul 9, 2012 Jul 9, 2012 | 2220 hrs | 1 | Yes 2 ✓ No | | | |
| Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should the | Certification | 3 Suicide 6 Could not be determined (Specify) 1 pocal Street | | t, factory, office | | or Town, Sta | | ral Route Number, City |
| Div the Hospital or hin 24 hours afte the Funeral Din npletely filled in | | 29a. Certifier | | red at the time, o | | | | |
| To the Hos within 24 h To the Fur completely | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. | | | | | | |
| To viti | Me | 29b-Signature and title of certifier | AT | 29c. Licen | | Ī | 29d. Date signed (Mo | nth, Day, Year) |
| | | Ce / MM | 16 | 0.0 | .M.E. | | July 11, 2012 | |
| 5 | | 30. Name and address of person who completed cause of death/(Ite Zabiullah Ali, M.D. Assistant Medical Examine | | altimore Stre | eet. Baltimore | MD 21223 | | |
| S | tate | | | | | | | |
| Regis | | JUL 1 3 2012 Server B. | ture face | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22122 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MICHAEL Month Q:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death CROFTON RUFTOW AREV REHABILITATION ARUNDEL ANNE Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XXM 2 🗆 F Months Hours SEPT 7, 1917 Director 220.05.8112 Country PA 94 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2xx No MD ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 1st AVE. SW 21061 items ; 11. Marital Status ↑↑ 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Ex-miner 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Specify Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LAWYER IAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN DEMYAN SUSANNA ROODY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 GLENVIEW AVE. GLEN BURNIE, MD 21061 ALEX DEMYAN **NEPHEW** 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) MDVETCEM CROWNSVILLE 7.13.2012 CROWNSVILLE, MD Sign Aure of Funeral Service Lice see FINK FUNERAL HOME P.A. K. CRECORN FINK M01148 426 CRAIN HWY SW CLEN BURNIE, MD 21061 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition CARDIAC Medical resulting in death) Due to (or as a consequence of): Examine SSENTIAL ENTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of. Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DEMENTIA 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA 24a. Was an autopsy performed? Yes 2 1 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, the Hospital Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 0 MD D0062395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALFONSO GOMAR 6934 AVIATION PLVD, UNITB GLEN BURNIE MD 21060 MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

3. Date filed (Month, Day, Year)

PREETINDER



30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940 W.BALTIMURE ST. BALTIMURE MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Harmon Duvall Physician/ 10 Day 2012 Year July 00:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Harrford County Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 217-20-2389 1 **X** M 2 □ F Director 87 Jan. 5, 1925 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location Forest Hill 10d. Inside City Limits Directo Harford County Maryland 1 🗆 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 109 Forest Valley Drive 21050 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: Completed 3 🗌 Widowed 4 💢 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) State Highway Administration Clerk 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Smith 17. Father's Name (First, Middle, Last) Harmon Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 Graceton Road, Pylesville, Manyland 21132 Gregory Duvall (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Evans Funeral Chapel 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State July 11, 2012 | Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fyars Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Orobabi Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury ohysician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the should be detached Division of Vital Records, P.O. DovallyJame Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes Investigation 6 Could not be after death 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 1)0057223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapenka Ur. Bel 21014 MA Day, 12. Registrar's Signatur State Registrar DHMH 17 Rev 06-2011

DOD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ď3 Marcus W. Dieterle July 2012 7:35 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Oakcrest Village Parkville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) Hours 310-14-7930 Director 1 🌠 M 2 🗆 F 89 Yrs Dec. 11. 1922 Indiana Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director must be notified 1 Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8820 Walther Blvd. Apt. 1608 21234 U.S.A. items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1940 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 🗌 Yes 2 💢 No Specify: White 3 🛮 Widowed 4 🗆 Divorced 1993 Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Civil Service Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Ruth Freyberg Marcus L. Dieterle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 Elmhurst Ave. Parkville, Maryland 21234 John Dieterle (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State July 14, 2012 5 Other (Specify) Bel Air, Maryland Bel Air Memorial Gardens 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 reral Service Licenytee Jeffrey R. Testerman Testernan (MO1543) disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or hear failu Immediate Cause (Final disease or condition resulting in death) failure. List only one cause on each line. Interval Between Onset and Death Physician/ erebrovascy Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f q | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CAS, HTY 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

State

Registrar
DHMH 17 Rev 06-2011

Blvd. Parkville MO 2/234

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

KISON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 06-26-2012 Physician/ 9:37 P Margaret Jane Dixon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Director 406-48-3743 75 Kentucky 12-19-1936 Usual Residence of Decedent or 28e-f shov permit. Pege 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Health end Mentel Hyglene. Importent: If Itam 27 is marked other then "neturel", or Items 23e or 28e-f show say injury or other treumetic event, Ite Madical Exminer must be exitted at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2x XNo Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21122 7901 Camp Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) School System Cafateria Manager Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Lee Goodpaster Linville Lee Whitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Coldstream Trail, Felton, PA 17322 Sandra Grimes - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Prk. 07-07-2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To this Hospital or Attending Physicien: The lew requires thet the deeth certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use as the burlai-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

3708 MOUNTAIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Registrar's Signature

Christophen de Boria

31. Date filed (Morth, Day, Year)

2012

PASAdeNA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Eloise Sneidonia | | 1- For State | Sta | ate of Maryla | | | nent of cate of | | and | Mental i | Hygiei | | 2 | 01 | 2 2212 |
|---|----------------|--|---------------------|---|-------------------------|--------------------|---|-------------------------|------------|--|--------------|--|-----------------------------------|---------------------|---|
| Physician Medical Examin | n/ | Registrar 1. Decedent's Name (I Eloise ELOISI | e Shei | e,Last) Ldonia Da EIDONIA D | vis | | | - | | | | Reg. te of Death nth E y 10, 201 | | | 3. Time of Death 0720 hrs |
| | ı | 4a. Facility Name (if n | ot institutio | | | | 41 | o. City, Tow Temple | | cation of Dea | ath | y 10, 201 | 4c. County o | | |
| Funeral Director | | 5. Social Security Nun | | 6. Sex | 7. Age (In | | | If Under 1 | Year | If Under 24H Hours M | lin. | | (MM/DD/YYYY) | 9. Birti Foreigi | hplace (State or GEORGIA |
| - 11 | ŀ | 252-64-466 Usual Residence of Do 10a. State 10 | | 1 M 2XXF | 1400 | | 71 Yrs. | | | | (| 02/28, | /1941 | Col | untry) |
| land f show any | 0. | MARYLAND | PRIN | CE GEORGE | . 1 | City, Tow | | '' TEMPL | E H | ILLS | | | | | 10d. Inside City Limits 1 Yes 2 No |
| vith the Maryland 123a or 28a-f show a cotified at ooce. | | 10e. Street and Numb 4700 BII | | REE LANE | | | | 10f. Zip Co | de 2074 | 48 | | 10g | . Citizen of What | | try? |
| | Funeral | 11. Marital Status 1 Never Married | | 12. Was Dec | | | | | | nic Origin? (lexican, Puer | | | 14. Race White | | can Indian, Black, |
| ours after | ≥∣ | 3 X Widowed 15. Decedent's Educ | | orced If Yes, Give Yea or Dates: cify only highest grad | | ed) 16a | a. Decedent | | cupation | specify: (Give kind o O NOT use re | | ne 1 | Specify: 6b. Kind of Bus | | |
| 21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "oatural", evec, the Medical Examiner | Completed | Elementary/Second | | College (1 | 1-4 or 5+) | | POSTA | | | ONOT use in | eureu) | 1 | UNITED | POS' | TAL SERVICE |
| 215-0 be filed w ntal Hygic rked othe | မှု လ | 17. Father's Name (Fi unknown | rst, Middle, | Last) | | | | | 18. | Mother's Nar RUTH | | | iden Surname) | | |
| MD 21 12 should th and Me 127 is man umatic ev | 2 | 19a. Informant's Name | is/ S | | | - 1 | | | | | | | er, City or Town | | |
| more, Pages I and ent of Heali iot: If item | | 20a. Method of Dispos 1 X Burial 2 | sition Cremation | 3 Removal fr | om State | 20b. Place crem | e of Disposit atory or othe GROVE | on (Name o er place) | of cernet | tery, | Date | 2 | 20c. Location - | City or | Town, State |
| Baltin permit. P. Departmer Importso injury or | - | Donation 5 21. Signature of Funer | | | | OAK (| | | | | know COMM | unity | CHATHAM FUNERA | L H | OME P.A. 21217 |
| Physician /Medical | + | 23a. Part I. Enter the of failure. List only | | on each line. | | | not enter the | mode of a | ying, su | ch as cardiad | or respir | atory arrest | JRE, MD , shock, or hea | rt | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Fin or condition resulting i | | Due to (or as a | | | lar Diseas | e compl | icated | by Hyper | thermia | a | _ | | Death |
| | Examiner | Sequentially list condi if any, leading to imme cause. Enter Underly | ediate ing Cause | Due to (or as a | consequen | nce of): | | - | | | | | 7 | | |
| ecuted and transit | | (Disease or injury that events resulting in dea | ath) Last | Due to (or as a | consequen | nce of): | | | | | | | | | |
| be exe sician gunial - | Medical | UNPENDED | | | #1perl | | 929 , 7/ | 25/20 | 12, | VS. | | | 23d. Date of o | delivery | |
| Box 68760 e death certificate b the attending physic ed for use as the bu | Cia | 23b. Was decedent pre- past 12 months? 1 Yes 2 ✓ No | | 1 Live b | oirth nant at time | | 2 Feta | l death er (Specify) | 3 | Ectopic preg | nancy | | Month | | ay Year |
| aw requires that the ras been signed by t | 2 | Part II. Other significa | ant conditi | ons contributing to | death but i | not result | ing in the un | derlying cau | use give | en in Part I. | | | | | he cause of death? ably 4 Unknown |
| Rec The I | Completed | | | | | | | | | | 1 | 4a. Was an autopsy performe ✓ Yes 2 | pr ed? de | | opsy findings available ompletion of cause of |
| Vital hysiciao: | To Be | 25. Was case referred examiner? 1 ✓ Yes 2 | No Medical | Hospital: 1 | Inpatient 2 | 2 ☐ ER/ | Outpatient | | | Death (Chec | sing Home | | esidence 6 | Other: | Scene |
| ion of teodiog Pheath. | | 27. Manner of Death 1 Natural 2 Accident | | ing 28a. Date FOUND | Day,Year) | FC | o. Time of Inj DUND: 05 hrs | ury 28c. 1 | | at Work? 2 ✓ No | | | w injury occurre sed to enviro | | ntal heat |
| Division Brospital or Atteed 24 hours after death Frueral Director: etely filled in by the | Certification: | 3 Suicide 6 | | I not be 28e. Plac | e of Injury - Reside | | farm, street | factory, off | ice build | ding, etc. | or | Town, Stat | | | al Route Number, City MD |
| To the Hospit within 24 hour To the Ruger; completely fill | ल | | | ysician: To the bes niner:On the basis and manner s | of examinati | | | | | | | | | | |
| | Ĭ | 29b. Signature and title | e of certifier | | | | | | .C.M.I | | | | 29d. Date signe July 11, 201 | | th, Day, Year) |
| 101 | + | 30. Name and address Donna M. Vind | The second second | · | | • | , | V. Baltim | ore St | treet, Balt | imore. | MD 2122 | 23 | | |
| Star Registra | _ | 31. Date filed (Month, | Day, Year) | 32. R | gistrar's Sig | | La | | | -, | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

OOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{2}\underline{012}$ Shelly Joann Strahl Douglas July 6 Medical 8:52 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9596 Muirkirk Road T-1 Laurel Prince George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days December 27, 1949 Minnesota Hours Min. 473-60-2737 **Director** Yrs 62 Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Texas Tarrant 1 Yes 2 □ No Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 Leslie Drive 76012 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation المالية عند عام 1945. اجتم Hygiene. احمد than "r 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 5+Certified Public Accountant Law Be 17. Father's Name (First, Middle, Last) th and Mental F. 7 is mark 18. Mother's Name (First, Middle, Maiden Surname) 2 Carrol Strahl Dorothy Olsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Adam Castillo / Son 9596 Muirkirk Road T-1, Laurel, Maryland 20708 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 10, 2012 Bethesda, Maryland Signatur of Funeral Service Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final SOVAMOUS CELL LUNG CANGER Physician/ disease or condition resulting in death) Medica Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events ŭ physician are the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Por in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has b lirector, page 2 s autopsy performed' 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: 4 Nursing Home 5 Residence 6 Other Specify မှ 1 Inpatient 2 ER/Outpatient 3 DDA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending (Month, Day, Year) work after death. Accident 1 Tes 2 🗌 No Investigation within 24 hours after de To the Funeral Directo completed filled in by th 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) D31761 MD 30. Name and add/est-of person who completed cause of death (Item 23a) (Type, Print)

Brian O'Connor, M.D. 501 West 7th Street, Ste. 1A, Frederick, Maryland 21701 16 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Thelma Eaddy 7:45A M Medical 07/05201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5008 Elmer Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours (Month, Day, Year) Country)North Director 238-62-8943 1 [] M 2 [X] F 77 04/16/1935 Carolina or than "nature!", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5008 Elmer Avenue 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Day Care Provider 12th grade 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If Item 27 is marked o any Injury or other traumatic ever Baldy L.Arrington Lessie Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie F. Hardy 5008 Elmer Ave.Baltimore MD.21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Dundalk Maryland Bayview Crematory 07/11/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home Reisterstown Road Baltimore MD.21215 5240 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Medical resulting in death) Due to (or as a cons auence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami use es the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician Physician/Medical thet the deeth certificete be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 5 Other (specify) Month Day Year To the Hospital or Attending Physician: The lew requires thet the dee within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the e completely filled in by the funeral director; page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 NAO ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centifying Nufse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) 71040

State Registrar NCHARIES

2012 ETIE

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30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month: Ball Year)

| 2-05075 iara Sha | niece | Ellio | Please Typ | e or Print i | | | | | • | | .egibl | e. | | | |
|---|---|-------------------|--|---|---|------------------------------|-------------|-----------------------|------------------|------------------------------------|----------------------------|-------------------------|------------------|------------------------|------------------|
| | | | 1- For State Registrar | | | rtificate o | | th | | | Reg. No | . 2 | 013 | 2 2 | 21: |
| Pl Medical I | hysici Exami | | Decedent's Name (First, Middle Tiara Shani) | ece s E | A SHANII lliott | ECE ELL | IOTT | | | 2. Date of D Month July 6, 2 | Day | Yea | | Time of De 1442 hrs | |
| | | | 4a. Facility Name (if not institution Meritus Medical Cente | | umber) | | | | ocation of Death | | 4 | c. County o | | | |
| Fu | ineral | | | 6. Sex | 7. Age (In yrs. | last birthday) | | erstown der 1 Year | If Under 24Hrs | s. 8. Date of | | Washing | | olace (State o | or |
| | ector | | 215-21-8837 | 1 M 2 X F | 2 | 23 yr | Monti | hs Days | Hours Mir | 08/2 | 29/1 | 988 | Foreign Count | try) MD | |
| | any | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Loca | tion | | | | | | 1 | 0d. Inside Ci | ity Limits |
| and | ≥ | ō | MD N/ | A | | | Balt | cimor | е | | | | 1 | Yes 2 | 2 No |
| e Maryl | or items 23a nr 28a-f shn must be notified at once. | Director | 10e. Street and Number 296 S. Mason | C+ | | | 10f. Zij | p Code 212 | 21 | | | tizen of Wh | | /? | |
| with th | s 23a i | | 11. Marital Status | | cedent Ever in U | .s. 13. W | as Deced | | inic Origin? (S | pecify Yes or | | U.S. | | n Indian, Bla | ick, |
| r death | or iten must b | Funeral | | Armed F | 2 X No | lf. | | _ | Mexican, Puerto | Rican, etc.) | | White | | _ | |
| ırs afteı | ural", miner | ğ | 3 Widowed 4 Dive | orced If Yes, Give Ye or Dates: cify only highest gra | | 1 16a Decede | | No a | specify: | work done | 16b | Specify: Kind of Bus | Bla | | |
| 5 72 hou | in "nat | letec | Elementary/Secondary (0-12) | College (| 1-4 or 5+) | during n | nost of wo | orking life. D | O NOT use ret | | | | | , | |
| .003 within | Hygiene. d other than "natural", o , the Medical Examiner i | Completed | 17. Father's Name (First, Middle, | 1 ye | ear | | Scho | | .Mother's Name | - /Firet Middl | | N/A | | | |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland | I Mental Hygiene s marked other t ic event, the Me | a | Ephrem Ellic | | | | | | Terri | | | i Suriame) | | | |
| D 21 | nt of Health and Mental it: If item 27 is marked other traumatic event, | ပ | 19a. Informant's Name/Relationsh Terri Davis (1 | | | | | | nd Number or I | | | | | | |
| e, MD | Department of Health and M Important: If item 27 is m injury or other traumatic | | 20a. Method of Disposition | | | Place of Dispo | sition (Na | me of ceme | | Date | | Location - | | | |
| MOF | ent of unt: If | | 1 X Burial 2 Cremation 4 Donation 5 Other Sp | | | crematory or of | | | . 07/ | /14/12 | 2 Ba | ltim | ore, | MD | |
| Baltimore, permit. Pages I an | Departm mports ajury o | Ì | 21. Signatur f Funeral Service | Licynsee | | 227 | VSET | Address of | Brown ulton | | | | | | 2121 |
| | ician | 91 6 | 20a. Part I. Enter the disease, or | complications that | aused the death | | | | | | | | | Approximate | 2121 Interval |
| (Ma | dical niner | | failure. List off one cause of the cause of the cause (Final disease | on each line. a. Multiple In j | iuries | | | | | | | | 4 | Between Or Deat | |
| 1 | | 1 | or condition resulting in death) | Due to (or as | a consequence o | of): | | | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as | a consequence o | of): | | | | | | | _ | | |
| _ | ij | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequence o | of): | | | | | | | | | |
| executed | the attending physician and ted for use as the burial - transit | | UNPENDED | d. X AMENDED | | | | | | | | | | | , |
| 60 , ate be e | hysicia e buria | Medi | IF FEMALE: | # P 23c. If yes, | ER ME G | | 4/12 | TRT | | | 23 | 3d. Date of | delivery | | |
| 687 certific | nding p se as th | jan/l | 23b. Was decedent pregnant in the past 12 months? | e 1 Live | | 2 Fe | etal death | | Ectopic pregna | ancy | | Month | Day | Y | 'ear |
| Box 68760, e death certificate bo | the atte ed for u | Physician/Medical | 1 Yes 2 No 9 V Unk | nown 9 Unkn | own | ٥ ا | ther (Spe | | | | 7.5 | | | | |
| P.O. | signed by I be detach | Š | Part II. Other significant condition | ons contributing t | o death but not r | esulting in the | underlying | g cause give | en in Part I. | | | | | cause of de | |
| rds, require | s been sig should be | Completed | | | | | | | | 24a. Wa | as an | 24b. W | ere autop | sy findings a | available |
| Division of Vital Records, rai or Attending Physician: The law require | 2 Z | d Wo | | | | | | | | pe | topsy rformed? s 2 N | de | eath? | pletion of ca | |
| tal R | his certificate director, page | BeC | 25. Was case referred to medical examiner? | Hospital: | | | | Int | Death (Check | | | | | | |
| of Vi g Physi | After this uneral din | 유 | 1 Yes 2 No 27. Manner of Death | 28a. Date | Inpatient 2 | ER/Outpatien 28b. Time of | | 28c. Injury a | | ng Home 5 | | | Other: | | |
| ion (| eath. Ior: Af the fun | tion | 1 Natural 5 Pendi 2 Accident Inves | ing Jul 6, 2 | n Pay, Year) 012 | 1338 hrs | | 1 Yes | 2 V No | Passenge | r auto | collision | | | |
| Jivis Lor At | after d Direct d in by | Certification: | 3 Suicide 6 Could | not be 28e. Plac | ce of Injury - At h | | | y, office build | | 28f. Location or Town | , State) | | | | |
| Hospits | Funera Funera ely fille | | 4 Homicide | ysician: To the be | , | | | e time, date | | Rt. 40 @ G | | | | erstown, Mi | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be | within 24 hours after death. To the Funeral Director: After ti completely filled in by the funeral | edical | one) 2 Medical Exam | niner:On the basis and manner: | of examination a | | ation, in m | y opinion, d | eath occurred a | | ite and pl | ace, and du | e to the c | | |
| | | ž | 29b. Signature and title of certifier | r | | | 29 | c. License n | | | | Date signe y 8, 2012 | | Day, Year) | |
| 71 | | | 30. Name and address of person | who completed cau | se of death (Item | 1 23a) | | O.O.IVI. | . | | July | , 2012 | | | |
| 1/0 | | | Ana Rubio M.D., Ph. D | . Assistant | Medical Exa | miner 900 |) W. Ba | ltimore S | Street, Baltir | more, MD | 21223 | | | | |
| | S1 Regis | ate trar | 31. Date filed (Month, Day, Year) | 2012 32 | egistrar's Signati | D. La | west . | , | | | | | | | |
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Registrar DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | 1 | For State Registrar | | State of Ma | arylanc | | ırtmen <i>tificate</i> | | | ina ivi | ental Hy | giene Reg. No | 20 | 112 | 22131 |
|---|--|--------------------------|--|------------------------------------|--|---|------------------------------|-------------------------------|---------------------------|-----------------------------------|--------------------------|--|----------------------|------------|--|--|
| | Physicia | 1/ | 1. Decedent's Name | | - | 1/1 | | | | | | 2. Date of De | | у | Year | 3. Time of Death 5:15P M |
| - | Medic Examin | al - | 4a. Facility Name (if | | ean () | She | ν <u>γ</u> | | | Location of | f Death | 001y 0, | 4c. | . County | of Death | 0.10 |
| j | | | 3215 Taylor | | 17 A | - // | - | Park' | ville | If Under 2 |)/ Hrs I | 9 Date of Bir | | Balti | | lace (State or Foreign |
| | Funeral Director | | 5. Social Security Nu 218 36 832 Usual Residence o | 3 1 | x | e (In yrs. las 1 | Yrs. | Months | Days | Hours | | 8. Date of Bir (Month, Da December | 5, 1 | 940 | Count | |
| | fand show dat | tor | 10a. State | 10b. County | | | Town or Loc | ation | | | | | | | 1 | Od. Inside City Limits |
| | e Mary r 28a-1 notifie | Sirec | Maryland 10e. Street and Num | Baltimore | | Park | ville | 10f. Zip | Code | | | | 10a Cit | tizen of \ | What Coun | 1 Yes 2X No |
| | with the 23a or | Funeral Director | 3215 Taylo | | | | | | 1234 | | | | rog. on | USA | | |
| 36 | within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at | þ | 11. Marital Status 1 Never Marri 3 Widowed | | 12. Was Decedent E Armed Forces? 1 Yes XX If Yes, Give | | | Vas Deced Yes, spec | | | in? (Spe Puerto I | cify Yes or No- Rican, etc.) | - 1 | Blac | e - Americ ck, White, e White | |
| 21215-0036 | hours 'natura' | Completed | | 15. Decedent's Ed | Year or Dates. | | 16a. Deced | ent's Usua | al Occupa | ation uring most | of workir | na | _ | | usiness/Inc | dustry |
| 121 | ithin 72 ene. r than ' the Me | Com | Elementary/Seco | | College (1-4 or 5 | 5+) | Account | D NOT use | retired) | | | .9 | Sel | f Emo | oloyed | |
| land 2 | should be filed within and Mental Hygiene. I is marked other tha raumatic event, the I | as l | 17. Father's Name (F | | ACCCO! | <u> </u> | | 18. Mothe | | (First, Middle, augh | | | | | | |
| ≥ ¾ € Yvonne Shealy (Daughter) 2500 Pond Branding | | | | | | | | | | Road | r or Rura Lees | Route Number | er, City or South | Caro | State, Zip C Lina 2 | 29070 |
| Baltimore, | 0 0 = = | | | | Removal from State | ce | ace of Dispo metery, cren | natory or o | ther place | | | Date 112 | | | - City or To e ,Mary : | |
| Balti | permit. Page Department Important: any injury o once. | | 21. Signatule of Fur | har BS | De S | | 22 Li 7 | . Name an assahn 401 Be | ad Addres Fune Lair | s of Facility ral Ho Road B | me In altin | ıc ore Mary | land | 2123(| â | |
| | | | shock, or hear | t failure. List only o | olications that caused ne cause on each line | d the death e. | . Do not ente | er the mod | e of dying | g, such as o | cardiac o | r respiratory a | rrest, | | | Approximate Interval Between Onset and Death |
| | Medical | | Immediate Cause (disease or condition resulting in death) | | a. Richard Due to (o as | a conseque | eno ot: | Fa | ılı | re- | | | | | - | nows |
| | Examiner | Ļ | Sequentially list co | nditions. | b capi | S | - 0 | | | | | | | | | yes |
| | ed nsit | Examiner | Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or | lying injury | Due to (or as | r | ence of): | ait. | The s | ν. | | | | | | Viene |
| | cate be executed physician and the burial-transit | al Exa | that initiated events resulting in death) I | | Due to (or as | | | gra | 00- | | | | | | | |
| 68760 | ficate by physical properties of the last the la | Nedical | | | d | | | | | | | | | | | |
| Box 68 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transi | Completed by Physician/M | IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 1/2 9 ☐ Unknown | pregnant months? | 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown | 2 Fetal | Ideath 3 | Ectopic Other (sp | | y | | | 8 | | ate of deliver | ery Day Year |
| s, P.O. | v requires that the seen signed by should be detact | d by Ph | Atr | al fit | ontributing to death b | | ulting in the u | inderlying | cause giv | ren in Part I | | | | | | ne cause of death? |
| Records, | sician: The law requ s certificate has beer director, page 2 shou | omplete | Depr | reists or | | | | | | | | 24a. Was auto perl 1 \(\sum \) Yes | opsy formed? | | Were auto prior to co death? | psy findings available mpletion of cause of |
| Vital F | sian: Ti ertificat ector, p | BeC | 25. Was case referr examiner? | . 1 | | | | | | ace of Deat | | (only one) | | | | |
| of Vil | ding Physic h. After this co funeral dire | 은 | 1 ☐ Yes 2 27. Manner of Deat | No | Hospital: 1 Inpat 28a. Date of inju | | ER/Outpatier 28b. Time of | | OA Othe | 4 ∐ Nu | | me 5 Res 28d. Describe | | | |) |
| o uo | anding rath. rr: After he fune | licate | 1-X Natural 2 Accident | 5 Pending Investigation | (Month, Da | | injury | М | work | | | | | | | |
| Division | ral or Atters as after de al Directo | Certificate: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Place of Inj | jury - At hor tc. (Spec <i>ify</i>) | me, farm, str) | eet, factor | y, office | | | 28f. Location City or To | | | er or Rura | Route Number, |
| | To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical | (Check 2 only one) 3 | ☐ Medical Exam ☐ Certifying Nur | iner: Or he besto iner: Or he basis of ser ractinoner. To h | examination. | and/or inves | tigation in | my opinio | on, death or | ccurred at | the time, date | and plac | e. and du | ue to the ca | use(s) and manner stated. |
| | To t With To t | | 29b. Signature and | title of gentiler | | | | | c. License | number | 164 | | 29d. Da | ate signe | ed (Month, | Day, Year) |
| | 81 | | 30. Name and add | 51. | completed cause of | death (Item | 23a) (Type, I | Print) | | | | 12. | 2.0 | 7 | 10, | 4.16 |
| | Sta | te | 31. Date filed (Mo | | 37 109ict | | | | | 4 m | نه کئے ہ | dim | ₹/\? } | 30 | | |
| | Registr | | .[| 111 1 3 20 | 12 Between | | ba | May | dis- | | | | | | | |

Please Type or Print in Black Indelible Jok. Fnsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lois B. Fritz June 2012 2 may 2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Parsonsburg Golden Gardens Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Davs Hours Min 193-18-9374 Director 90 Pa 11/1922 Usual Residence of Decedent 28a-f show 10b. County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified Ocean Citu Worcester 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral USA 21842 12549 Torquay Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Beth Stephens Ross Whipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12549 Torquay Road, Ocean City, MD 21842 <u>Kerry Kulha</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cremation Society of Pa 6/29/12 King of Prussia, Pa 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Auch Cremation Suces of Fa., Inc. Signature of Funeral Service Licensee 4100 Jonestown Road, Harrisburg, Pa 17109 23a. Part I. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line.

Im edit to Cause (Final disease or condition

And Static Lucian Cause (Final disease or condition and the death). Onset and Death Physician/ dis ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death Unknown s been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 st autopsy certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Assisted
6 🖾 Other (Specify) Living Hospital: Other: 1 🗌 Yes ၉ 4

Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WERNER F. FURTH JULY 9,2012 8:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE TOWSON TOWSON BALTO. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Months Hours Min 579-40-8532 1 **X** M 2 \square F Director 81 SEPT. 12,1930 **AUSTRIA** 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Director notified 1 Yes 2 XNo MD HARFORD ABINGDON or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 725 BURGH WESTRA WAY 21009 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 'natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the PRINCIPLE **ENGINEER** MARTIN MARIETTA event, Be Department of Health and Mental H
Important If item 27 is marked oft,
any injury or other traumatic mental. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH H. FURTH EMMA KAHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **SPOUSE** MARY FURTH 725 BURGH WESTRA WAY ABINGDON, MD. 21009 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other place, 7-12-2012 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR Signature of Funeral Service Licensee MACPHAIL ROAD REL ATR. MD. Part 1. Enter the disease, on shock, or heart failure List is that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Englandally liet on ditors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of inding physician ause as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death igned by the ar signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate 1 ☐ Yes 2 🗷 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 2 No ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 27. Manner of Death s after death. Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours To the Funeral Medical f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of contifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

29d. Date signed (Month, Day, Year)

Lutherwell IMD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C 7 Physician/ Itoward Finley 0635 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 4c. County of Death **Examiner** naryland timore General Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours 10^M2th5-1 926 276-22-0226 Ohio Director 85 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes X No Hanover MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral United States Chesapeake Mobile Ct. - Lot 59 21076 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 x Yes 2 No 1952

If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1952 Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Maintenance Mechanic State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cora Coddle Dewey McKinley Finley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chesapeake Trailer Ct., Lot 59, Hanover, MD 21076 Health a Important: If item 27 any injury or other tra Sue E. Finley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date è 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other injury or 07-09-2012 Meadowridge Mem Park Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Candian o

Due to (or as a consequence of Physician/ Yeer Medical resulting in death) Examiner Coronant Sequentially list conditions, if any course cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Gibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an anafare page 2 s performe certificate 2 🗌 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b, Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After 1. Natural 5 Pending Accident 24 hours after death. Funeral Director: A Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1) 43386 us ! 07.05. 2012

Registrar

DHMH 17 Rev 7/2009

State

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Balkwore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUL 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| anz Josef Gm | nahl | State of Maryland / Departmen 1- For State | | | and I | Mental I | - | | 21 | 012 2213 |
|--|----------------|---|-----------------------|--------------------------------|------------------------|-----------------------------|-------------------------------------|---------------------|--------------------------|--|
| Physici edical Exam | | Decedent's Name (First, Middle,Last) | | | | | 2. Date of De Month | Day | | 3. Time of Death 1823 hrs |
|) | | 4a. Facility Name (if not institution, give street and number) | 41 | b. City, Tow | n, or Lo | cation of Dear | July 5, 20 | 4 | lc. County of [| Death |
| Funcion | | 1739 Fairhill Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd | | Edgewa | | H Lindor 24H | ro To Data of B | | Anne Arur | |
| Funeral Director | | 217-90-5241 1\(\infty\) M 2\(\supers\) \(61\) | Yrs. | | Days | If Under 24Hi Hours Mi | | • | ÎF | 9. Birthplace (State or Foreign Country) Germany |
| ń. | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or | | | 1 | | 1 | | 1701 | |
| nd ibow any see. | _ | Maryland Anne Arundel Edgewat | | ρΠ | | | | | | 10d. Inside City Limits 1 Yes 2 No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number | \neg | 10f. Zip Co | de | | | 10g. Ci | tizen of What | |
| eath with the Maryland items 23a or 28a-f sho ust be notified at once. | | 1739 Fairhill Drive 11. Marital Status 12. Was Decedent Ever in U.S. 11 | | | L037 | | | | S.A. | |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No | | | | | Specify Yes or N to Rican, etc.) | 0- | 14. Race - / White, e | American Indian, Black, etc. |
| s after c | ē | 3 Widowed 4 X Divorced If Yes, Give Year | | | No s | | | | | White |
| 5-0036 led within 72 hours Hygiene. other than "natur: | ted | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | ecedent' ring mo | s Usual Occ st of working | upation glife. Do | (Give kind of NOT use re | f work done etired) | 16b. | Kind of Busin | ness/Industry |
| 21215-0036 unld be filed within 7 Mental Hygiene. marked other than | Comple | | aint | er | | | | | Constru | |
| 215-00 e filed wit al Hygien sed other nt, the Ma | Be Co | 17. Father's Name (First, Middle, Last) Franz Josef Gmahl + Son | | _ | 18.1 | Mother's Nam | ne (First, Middle, | Maide Raa | n Surname) | ≥, Laurel,Maryl |
| 212 nould b nd Ment is mark | To E | 19a. Informant's Name/Relationship (Type, Print) | | | Street ar | nd Number or | Rural Route Nu | mber, (| City or Town, | State, Zip Code) |
| and 2 sho ealth and tem 27 is traumati | | Franz Josef Gmahl: Son 81. 20a. Method of Disposition 20b. Place of E | | | | | aurel, l | | | 20724 ity or Town, State |
| Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If them 27 is marked oth injury or other traumatic event, the 1 | | 1 Burial 2 X Cremation 3 Removal from State crematory | y or othe | er place) | | | -12 -1 2 | | | r, Maryland |
| Baltir permit. F Departme Importal | | 4 Donation 5 Other Specify: Ardent 21. Signature of Funeral Service Licensee | | | | | | Fur | neral (| Chapel, P.A. |
| | | Muhau / Marcullo 23a. Part I. Enter the disease, or gomplications that caused the death. Do not e | 600 | 9 Har | for | d Road | .Baltimo | ore. | .Marvla | and 21214 |
| Physician /Medical | | failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia by hanging | onter the | e mode or d | ying, suc | ar as cardiac | or respiratory ai | rest, si | lock, or neart | Approximate Interval Between Onset and Death |
| Examiner | | or condition resulting in death) Due to (or as a consequence of): | | | - | | | | | |
| | ier | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| executed an and al - transit | | d | | | | | | | | |
| be be | ledical | UNPENDED X AMENDED 17,18 per f | h g | 929 7- | -13- | 12 vt | | | | |
| Box 6876 death certificate the attending phy do for use as the b | an/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 | Feta | al death | 3 | Ectopic pregr | nancy | 23 | 3d. Date of de Month | elivery Day Year |
| Box e death co | Physici | 4 Pregnant at time of death 5 Yes 2 No 9 Unknown 9 Unknown | Othe | er (Specify) | _ | | | | | |
| .O. E hat the ed by th | by Ph | Part II. Other significant conditions contributing to death but not resulting in | n the un | iderlying cau | use give | n in Part I. | | | | ite to the cause of death? |
| rds, P.C requires that been signed hould be deta | | | | | | | | | | Probably 4 Unknown |
| COCC law re has be e 2 sho | Completed | - | | | | | 24a. Was auto | | prio | ere autopsy findings available or to completion of cause of ath? |
| tal Rec | | 25. Was case referred to medical | | 26.F | Place of | Death (Check | | 2 🗸 | No 1 | Yes 2 No |
| F Vits Physicia Physicia Physicia I direc | To Be | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp | | 3 DOA | Oth | er4 Nurs | ing Home 5 | | lence 6 🗸 | |
| Division of Vital Records, P.O. is or Attending Physician: The law requires that it as after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled in by the funeral director, page 2 should be detacled. | | 27. Manner of Death 28a. Date of Injury 28b. Tin 1 Natural 5 Pending Pownb. Day, Year) FOUND | | | | t Work? 2 ✓ No | 28d. Describe Subject ha | | | |
| Visicor Atter dea Director in by the | ficat | 2 Accident Investigation Jul 5, 2012 1810 h 3 Suicide 6 Could not be | | | | | | | and Number | or Rural Route Number, City |
| Spital c hours at neral D filled | Certification: | 4 Homicide determined (Specify) Shed | | | | | or Town, 1739 Fairhill | State) Drive, | Edgewater, | , MD |
| Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b | Medical | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation. | occurre estigation | ed at the tim on, in my opi | e, date a inion, de | and place, an | nd due to the cau | ise(s) a e and p | and manner as | s stated. to the cause(s) |
| To To con | Med | and manner stated. 29b. Signature and title of certifier | | | cense n | | | | | (Month, Day, Year) |
| | | Celier 1119 | 2 | 0 | .C.M.I | ≣. | | Jul | y 6, 2012 | |
| OV | | 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 | W R | altimore 9 | Street | Raltimore | MD 21222 | | | |
| S | tate | 31. Date filed (Month, Day, Year) 32. egistrar's Signature | 7.0 | | , cc., | | , IVIU Z 1223 | | | |
| Regis | | /001 | back | | | | | | | |
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Mildred S. Grempler July 5. 11:40 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Howard County Howard Columbia Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) If Under 1 8 Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) 217-12-5735 90 **Director** 1 □ M 2X F June 15,1922 Maryland 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 713 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 XNever Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Marine Hosoital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ျ Leslie Norfork Grempler Edna Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Grempler/brother and 2 s Health a 611 West Drive GlenBurnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 07/13/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Stephanic 22. Name and Address of Facility MacNabb Funeral Home, P/A. Custer 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ RESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE LUNG DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No this certificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🖪 No Hospita Other: ပ္ Hospers 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Hospital Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Prtifie 29c. License number 0 512 2012 July D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 ABBAS CEDAR MD COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2012ª John Alexander Grimm 6:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard Ellicott City Heartlands Assisted Living Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 217-20-5941 **Director** 1 💢 M 2 🗆 F 86 09-05-1925 Maryland Usual Residence of Decede 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3020 North Ridge Road, Apt. 210 21043 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1944

If Yes, Give

Year or Dates. 1945 Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🙀 No Specify: Specify 3 Divorced 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Joseph Paul Grimm Kathleen Agnes Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17401 White Dogwood Court, Mount Airy, MD 21771 Thomas M. Grimm - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 07-12-2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Ser 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE LUNG Onset and Death Immediate Cause (Final DISEASE CHROMIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of. If any, leading to immediate cause. Enter Underlying Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events -trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CEREBROVASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 30. Name and addres completed cause of death (Item 23a) (Type, Print) GLENWOOD MO 21738 STE.10 LOUTE 97 2465 ttu 2

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State Registrar 31. Date filed (Mont

| | | | For State | State of | Marylar | | | | | Mental Hy | giene | 212 | 221 | 20 |
|------------|---|-------------------------|--|--|-------------------------------|-----------------------------------|---|--------------------|---------------------|----------------------------------|--------------------------|------------------------------|---------------------------------------|---------|
| | | | Registrar 1. Decedent's Name (First, Middle | Last) | | Cer | tificate | of Deat | th | 2. Date of Dea | Reg. No | 116 | <u> </u> | 33 |
| | Physicia Medic | | , , | | uroff | | | | | July | _ | 2012 | 3. Time of Dea 5:58 P | M M |
| | Examin | | 4a. Facility Name (if not institution, | | per) | | - | own, or Locat | | , - | | ty of Death | , | |
| er di | Farment | | 4816 Morgan Dr 5. Social Security Number | | 7. Age (In yrs. | last hirthday) | Che | evy Cha | ase nder 24 Hrs. | 8. Date of Birt | | gomer | y place (State or For | reian |
| | Funeral Director | | 340-32-9362 | 1 X M 2 □ F | 71 | Yrs. | | Days Hou | | (Month, Day | | Coun | try) | eigri |
| | oor at | _ | Usual Residence of Decedent 10a, State 10b. County | | 10c. Ci | ty, Town or Loc | ation | | | | | | 0d. Inside City Liu | mits |
| | farylar 8a-f sh tified | ecto | | gomery | | Chevy | | 2 | | | | | 1 🗆 Yes 2 🎗 | |
| | a or 24 | Ö | 10e. Street and Number | | | | 10f. Zip C | | | | 10g. Citizen of | | - | |
| | th with ms 23 must | Funeral Director | 4816 Morgan Di | | | . L | | 0815 | 0.1.0.0 | | United | | | |
| 0 | er dea or ite miner | by Fu | 11. Marital Status 1 ☐ Never Married 2 🛣 Marr | | ces? 2 X No | If | Yes, specify | / Cuban, Mex | kican, Puerto | ecify Yes or No- Rican, etc.) | | ce - Americ ack, White, e | | |
| | urs aft tural", al Exa | ted | 3 Widowed 4 Divorced | If Yes, Give Year or Dat | | 1 | ☐ Yes 2 | No Spe | ecify: | | Specif | y: Wh: | ite | |
| 5 | 72 ho in "nat Medica | Completed | (Specify only highe | t's Education st grade completed) | | 16a. Deced | ent's Usual (ind of work of NOT use re | done during i | most of work | ing | 16b. Kind of E United | | | |
| 7 | within giene. er tha , the I | | Elementary/Secondary (0-12) | College (1-4 5+ | 1 or 5+) | 1 | ian E | * | | | Govern | ment | | |
| 2 | e filed ntal Hy ed oth event | To Be | 17. Father's Name (First, Middle, L Alexander Guro | • | | | | 18. N | | e (First, Middle, Levin | Maiden Surnan | ne) | | |
| ii yi | ould b nd Mer mark matic | | 19a. Informant's Name/Relationsh | | | 19b Mailin | a Address /9 | Street and Nu | | al Route Number | r City or Town | State Zin (| Padel | |
| , INIC | d 2 sh ealth ar 1.27 is ertrau | | Katharine Guroi | | | | - | | | vy Chas | - | | | |
| ב ב | pe 1 an t of He lfiten or oth | | 20a. Method of Disposition 1 Burial 2 Cremation | 3 Removal from S | State | Place of Dispos cemetery, crem | atory or other | er place) | July | Date 13. | 20c. Location | - | | |
| Daltillor | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important I fleem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 4 Donation 5 Other (S | pecify) | Mont | gomery C | | | 20 | 12 | Betheso | | <u> </u> | |
| מ | Depa Impo any i | | 21. Signaturie of Funcial Service L | ant | M013 | 05 Rố | bert A. 57 Wisc | Pumphr consin A | ey Fune venue, | ral Home/ Bethesda, | Bethesda Marylan | -Chevy d 20814 | Chase, In -3501 | c. |
| | | | 23a. Part 1/Enter the disease, or shock, or heart failure. List o | nly one cause on eac | h line. | | | | h as cardiac | or respiratory arr | est, | | Approximate Interval Between | 1 |
| - | h, sician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | a | static rasaconseq | Lung C | Cancer | | | | | 1 | Onset and Peath | 8 |
| | Examiner | | 0.500.000 | Due to (c | a a a conseq | deride oi). | | | | | | | | |
| | sit d | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (o | r as a conseq | uence of): | | | | | | 1 | | |
| | xecute al-tran | Exar | that initiated events resulting in death) Last | c. Due to (o | r as a conseq | uence of): | | | | | | | | |
| 3 | cate be executed physician and sthe burial-transit | dical Examiner | , | d | | | | | | | | | · · · · · · · · · · · · · · · · · · · | |
| 0 1 | ertitica ding ph se as t | w | IF FEMALE: | 23c. If yes, outc | ome of prean | ancv | | | | | | | | |
| 5 | eath certifica attending p | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live B 4 ☐ Pregn | irth 2 Fet ant at time of | al death 3 🗌 | Ectopic pre Other (spec | | | | | ate of delive onth | ery Day Year | |
| | es tnat the dea signed by the a l be detached f | Phys | 9 🗌 Unknown | g ∐ Unkno | | | | | | | | | | |
| ٠ | es tna signed I be de | by | Part II. Other significant conditio | ns contributing to de | ath but not re | sulting in the ur | nderlying cai | use given in F | Part I. | | | | e cause of death pably 4 🛣 Unkr | |
| ή. Σ | requires been sig | Completed | | | | | | | | 24a. Was | | | osy findings availa | |
| ָ טַרָּ | Ine law ate has page 2 | dwo | | | | | | | | autop perfo 1 Yes | SV | prior to condeath? | mpletion of cause | of |
| 5 . | sician: The certificate l lirector, pag | Be C | 25. Was case referred to medical examiner? | Tri | | | | 26. Place of | Death (Chec | | 2 €5 140 | T Les | 2 110 | |
| · · | Physic this or | မ | 1 Yes 2 X No 27. Manner of Death | Hospital: 1 🔲 II | | ER/Outpatient | | Other: 4 [| | ome 5 K Resid | | |) | |
| 5 | nding ath. r: After ie fune | icate | 1 X Natural 5 ☐ Pending 2 ☐ Accident Investig | g (Month | , Day, Year) | injury | M 200 | work? | - 1 | 28d. Describe h | ow injury occur | rea | | |
| NO. | al or Attending P s after death. I Director: After t d in by the funers | Certificate: | 3 Suicide 6 Could r 4 Homicide determi | 28e. Place o | of Injury - At he | ome, farm, stre | et, factory, c | office | | 28f. Location (S City or Tow | | ber or Rural | Route Number, | |
| 5 | To the Prospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | 29a, Certifier 1 Certifying | Physician: To the be | st of mv know | rledge, death o | ccurred at th | ne time. date | and place a | | , | ner as state | ed. | |
| : | he Ho in 24 h he Fur ipletely | Medical | (Check 2 <u></u> Medical E | xaminer: On the basis Nurse Practitioner: | s of examinatio | n and/or investi | gation, in my | opinion, deat | th occurred a | t the time, date a | nd place, and du | ue to the cau | use(s) and manner | stated. |
| | Vith To the com | | 29b. Signature and title of certifier | Su | ie m | <i>D</i> . | | icense numb | | | 29d. Date signe | | | |
| | | | 30. Name and address of person v | | | | | | 774 | | July 1 | ∠, ∠U. | 1 4 | |
|) | | | James Kane, MD | 6400 Go1 | | | | Bethe | sda, N | laryland | 20817 | | | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) | | gistrar's Signa | ture | , | | | | | | | |

DHMH 17 Rev 06-2011

amend 23a,27,28a-f,per me,g932 10-12-12 sm

| 2-05228 arold William(| Galle | Please Type or Print in Bl | | | | | gible. | | |
|---|----------------|---|---------------------------------------|--|---|---------------------------|------------------------|--------------------------|--|
| aroid William | Can | away State of Maryland / 1-For State Registrar | | ent of Health ar ate of Death | id Mental Hy | _ | eg. No. | 201 | 2 2214 |
| Physici | an/ | Decedent's Name (First, Middle,Last) | | | 2 | 2. Date of Dea Month | | Year | 3. Time of Death |
| ledical Exam | iner | Harold William Gallaway 4a. Facility Name (if not institution, give street and number) | | 4h City Town | or Location of Death | July 11, 2 | 012 | unty of Death | 1008 hrs |
| ` | | 5619 Bartholow Rd. | | Sykesville | r Eocation of Death | | Carro | | |
| Funeral | | 015 50 0005 | (In yrs. last birt | thday) If Under 1 Ye Months Da | | 8. Date of Bi | rth (MM/DD/Y | YYY) 9. Birth Foreign | place (State or |
| Director | | 215-58-2885 1 ^X M 2 F | 46 ——— | Yrs. | ys Hours Will. | +/22/1 | 966 | | ntry) MD |
| any | | 10a. State 10b. County | 10c. City, Town | or Location | | | | T | 10d. Inside City Limits |
| Aaryiand 28a-f show | ō | MD Carroll | Eldersh | ourg | | | | | 1 Yes 2 X No |
| ith the Maryland 23a or 28a-f sho notified at once | Director | 10e. Street and Number | | 10f. Zip Code | | | | of What Count | |
| with the s 23a c e notif | | 5619 Bartholow Rd. 11. Marital Status 12. Was Decedent | Ever in U.S. | 21784 13. Was Decedent of H | ispanic Origin? (Spe | | | State | S an Indian, Black, |
| death v er item | Funeral | 1 Never Married 2 Married Armed Forces? | JNK | | n, Mexican, Puerto R | | | White, etc. | |
| s after ral", c | by | 3 Widowed 4 XXDivorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com | | 1 Yes 2 X N | | | Spec | лгу: | White |
| 72 hour n "natt | eted | Elementary/Secondary (0-12) College (1-4 or 5 | | Decedent's Usual Occupa during most of working life | | | 16b. Kind o | of Business/In | dustry |
| 5-0036 led within 72 hou Hygiene. other than "nat the Medical Exa | Completed | 12th | Da | airy Manager | | | Food | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | Be Co | 17. Father's Name (First, Middle, Last) Harold L. Gallaway | | | 18.Mother's Name (F Bernadet | | | | , |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hyggene. team 7: marked other than "natural", or items 23a or 28s-f she traumatic event, the Medical Examiner, must be notified at once. | To B | 19a. Informant's Name/Relationship (Type, Print) | 191 | o. Mailing Address (Stre | et and Number or Ru | ral Route Nur | nber, City or | Town, State, | Zip Code) |
| e, MD I and 2 sho Health and item 27 is | | Regina Gardner (Sister) 20a. Method of Disposition | | of Disposition (Name of ce | | Inster | | | |
| MOFE Pages 1 a nent of He nute If its | | 1 Burial 2 Cremation 3 Removal from Sta | te cremate | ory or other place) | <i>"</i> . | | | ion - City or T | |
| Baltimore, permit. Pages 1 at Department of Hee Important. If ite injury or other tr | | 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee COVEY DET DVR | js. car | roll Cremat | | /2012 | | eld, M | |
| | | Jamo Clay form | | 22. Name and Addres Burrier-Qu 1212 W. 01 | een Funera d Liberty | al Home | e and infiel | Cremat d, MD | 21784 |
| Physician /Medical | | Part I. Enter the disease, or commissions that cause of failure. List only one cause on each line. | the death. Do no sclerot ad and | it enter the mode of dying ic Cardiova: neck in juri | i, such as cardiac or r SCULAT DIS ES | espiratory arr sease c | est, shack o Omplic | ated | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a onse | | -Gardiovasco | lar Disea | 50 - | | | Death |
| | _ | Sequentially list conditions, b. | | | | | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | quence of): | | | | | | |
| cecuted n and - transit | Exa | events resulting in death) Last Due to (or as a conse | quence of): | | | | | | |
| ial ar | dical | X UNPENDED X AMENDED 23a | pt.II, | 27 per me g 7/16/2012,WS | 930 8-24-1 | 2 vt | | | |
| Box 68760, death certificate be ex he attending physician of for use as the burial. | Physician/Med | IF FEMALE: 23c. If yes, outcom 1 Live birth | e of pregnancy | | Ectopic pregnance | | | te of delivery | |
| x 68 th certi ttendin r use as | iciar | past 12 months? | time of death 5 | | Ectopic pregnand | -y | Mont | th Da | y Year |
| he de in | Phys | 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death | but not resulting | in the underlying cause | given in Part I | 23e Did to | phaceo uso c | antributa to th | e cause of death? |
| P.C es that igned be deta | ģ | Seizure Disorder | bat not roodining | y in the underlying educe | giver in tales. | | | | bly 4 Unknown |
| ords, w requir | Completed | | | | | 24a. Was | | | psy findings available mpletion of cause of |
| tal Reco | E O | | _ | | | | med? | death? | |
| Vital F ysician: ' ysician: ' his certific director, 1 | Be | 25. Was case referred to medical examiner? Hospital: 1 Innation | | | e of Death (Check on | | | | |
| Division of Vital Records, to or Attending Physician: The law required by the control of the control of the control of the control of the funeral director, page 2 should | မ | 1 Yes 2 No 28a. Date of Injur | y 28b. 1 | utpatient 3 DOA Time of Injury 28c. Inju | | Home 5 8d. Describe I | | 6 Other; | Scene |
| ision (Attendion r death. rector: Af | Certification; | 1 X Naturel 5 Pending (Month, Day,Ye 12 X Accident Investigation fd 7-11 | ear) | | | | | | ind struck |
| ivision or Attentate after death Director: | tifica | 3 Suicide 6 Could not be 28e. Place of Inju | - | rm, street, factory, office | | 8f. Location (S | Street and No | umber or Rura | Route Number, City |
| E 8 5 E | | 20a Cartifier | :Reside | | | ykesvi | lle,M | D | |
| To the Hos within 24 h | Medical | 25d. Certifier 1 Certifying Physician: To the best of my one) 2 ✓ Medical Examiner: On the basis of examand manner stated. | | | | | | | |
| Y H 3 F 8 | Me | 29b. Signature and title of certifier | | 29c. Licens | | | | signed (Mont | h, Day, Year) |
| | | (Colem) | 3-2 | 0.C. | M.E. | | July 12, | 2012 | |
| 9 | | 30. Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exa | , | W. Baltimore Stree | et, Baltimore, MI | 21223 | | | |
| S | ate | 31. Date filed (Month, Day Year) 32. Registrar | | | | | | | |

12-05116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| errick Gamble | | State of Maryland / Departm -For State Certific | nent of Health an cate of Death | id Mental Hygiene | Reg. N | 201 | 2 2214 |
|---|----------------|--|---|---|--------------------|--|--|
| Physician | 1/ | Registrar 1. Decedent's Name (First, Middle,Last) | | 2. Date of Month | Death Da | | 3. Time of Death |
| Medical Examin | | Derrick J. Gambl 4a. Facility Name (if not institution, give street and number) | | July 8, r Location of Death | 2012 | 4c. County of Death | 0206 hrs |
| | | 7122 Darlington Drive | Parkville | | | Baltimore Cou | inty |
| Funeral Director | | 5. Social Security Number 214-96-1027 6. Sex 7. Age (In yrs. last bir | rthday) If Under 1 Yea Months Day Yrs. | | | M/DD/YYYY) 9. Bir 1.980 Foreig Co | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | n or Location | | | · · · · · · · · · · · · · · · · · · · | 10d. Inside City Limits |
| | _ | MD Balt | cimore | | | | 1 X Yes 2 No |
| | 2 | 10e. Street and Number 4912 Gunther Ave. | 10f. Zip Code 212 | 206 | 10g. (| Citizen of What Cou USA | ntry? |
| th with the rems 23a | - I | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | | ispanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc. | | 14. Race - Amer White, etc. | can Indian, Black, |
| ter dea | | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year | 1 Yes 2X No | o specify: | | Specify:Blac | ck |
| ours af atural | <u>0</u> | 15. Decedent's Education (Specify only highest grade completed) 16a. | Decedent's Usual Occupa during most of working life | ation (Give kind of work done | 161 | o. Kind of Business/ | industry |
| 5-0036 led within 72 hours after they within 72 hours after they wither than "natural", the Medical Examiner. | Completed | College (1-4 or 5+) L2 t h L2 t h College (1-4 or 5+) L2 t h L2 t h L2 t h L3 t h L4 | Laborer | , | $ _{W}$ | harehous | se |
| d with ygrene other t | 튅 | 17. Father's Name (First, Middle, Last) | | 18.Mother's Name (First, Mid | ldle, Maid | en Surname) | - |
| 21215-0036 und be filed within 7 Mental Hygiene marked other than te event, the Medica | B B | Emmett Gamble | | | Vong | | |
| | | Rosalie Wongus (mother) | P.O. Box 25 | eet and Number or Rural Route 5623 Balto, N | ۸d. | 21224 | |
| ore, MC ges I and 2 sh tof Health an If item 27 ither trauma | | 1 Burial 2 Cremation 3 Removal from State | e of Disposition (Name of ce atory or other place) | | | c. Location - City or | |
| Baltimore, permit. Pages l at Department of Hec Important: If ite | - | 4 Donation 5 Other Specify: Trin 21 Signature of Euneral Spries Densee | ity Cemete | | | | |
| Bal permi Depar Impo | 4 | | 11412 F | ss of Facility B. Scruggs F Preston St | Ba1 | to Md | 21213 |
| Physician | 7 | 23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line. | not enter the mode of dying | , such as cardiac or respirator | ry arrest, | shock, or heart | Approximate Interval Between Onset and |
| IMedical Examiner | | Immediate Cause (Final disease or condition resulting in death) a Multiple Gunshot Wounds Due to (or as a consequence of). | | | | | Death |
| | <u>.</u> | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| be executed sician and unial - transit | <u>8</u> | d. UNPENDED AMENDED | | | | | |
| 50, tte be exc nysician e burial | Medical | IF FEMALE: 23c. If yes, outcome of pregnance | y | | -1 | 23d. Date of deliver | <u> </u> |
| Box 68760, a death certificate be the attending physici defor use as the burned. | | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death | 2 Fetal death 3 | Ectopic pregnancy | | | Day Year |
| Box death of | ysic | 1 Yes 2 No 9 Unknown 9 Unknown | 5 Other (Specify) | | | | |
| ires that the designed by the | <u>۾</u> | Part II. Other significant conditions contributing to death but not resulti | ing in the underlying cause | 3 | | | the cause of death? bably 4 Unknown |
| rds, require been signaled b | Completed | | | | Was an autopsy | | utopsy findings available completion of cause of |
| ician: The law requires to certificate has been a cector, page 2 should | E O | | | | performed Yes 2 | d? death? No 1 ✓ Y | es 2 No |
| tal Rection: The certificate ector, page | S B B | 25. Was case referred to medical examiner? Hospital: 1 locationt 2 FB// | | ce of Death (Check only one) Other Nursing Home | | | |
| Physic Physic critis stal dire | 욘 | 1 Yes 2 No loss limited 2 ER/6 | Outpatient 3 DOA D. Time of Injury 28c. Inj | iury at Work? 28d. Desc | cribe how | injury occurred | r: Scene |
| on of ending Pl ath. rr: After he funera | 틹 | 1 Natural 5 Pending Jul 8, 2012 015 | 56 hrs 1 | Yes 2 ✓ No Subject | shot | | |
| Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician physician by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director. | Certification: | 2 | farm, street, factory, office | or To | wn, State | | ural Route Number, City |
| Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | Medical C | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, done) Medical Examiner: On the basis of examination and/or | leath occurred at the time, or investigation, in my opinion | date and place, and due to the | cause(s) | and manner as sta place, and due to t | ted. ne cause(s) |
| S S Wit | ĕ | 29b. Signature and title of certifier | 29c. Licer | nse number | 29 | 9d. Date signed (Mo | onth, Day, Year) |
| | | Afle Braisse Gell 2 | 0.0 | C.M.E. | J | uly 8, 2012 | |
| HJ | 1 | 30. Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner | 900 W. Baltimore | Street, Baltimore, MD | 21223 | | |
| Sta Registi | | 31. Date filed (Month; Day, Year) 32. Project signature | parker | | | | |
| DHMH 17 Rev 1/20 | | JUL I S CUIC I MANUAL PO | RIGINAL | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ July 9 Mary Bell Grempler 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 1 □ M 2 💢 F 516-30-6972 81 3/30/1931 Canada Usual Residence of Decede show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🙀 No Maryland | Baltimore Stevenson ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral U.S.A. 10824 Stevenson Road 21153 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation skempler, MAR 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zella May Hall Benjamin Cleveland Hamilton Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Joseph Raymond /companion 10824 Stevenson Road Stevenson, Maryland 21153 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 7/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phyllician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical death certificate be P.O. Box 68760 the as IF FEMALE nse res, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 1 ☐ Yes 2 **②** 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director, After this certificate helety filled in by the funeral director, page perform 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ ER/Outpatient 3 DOA 1 Inpatient Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 5 Pending (Month, Day, Year) Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

within 2 To the I the

(Check

only one)

29b. Signature and title of certifie

2012

DHMH 17 Rev 06-2011

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

N. Pavillion Suite

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ E. Harms, Jr. Juliy 10 Pay 12:28 PM John 20°12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-28-1362 Director 1 XM 2 □ F 89 June 26,1923 Baltimore, MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director Parkville MD Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2827 Erie Avenue Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced WWII Specify: White Year or Dates. Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 BG&E College (1-4 or 5+) Electrical Engineer æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John E. Harms, Sr. Rose Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Perryoak Place Baltimore, Maryland 21236 Janice Palin- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or otl 20c. Location - City or Town, State July Date 14, Evans Funeral place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, MD 2012 4 Donation 5 Other (Specify) Chapel Bel Air Signature of Funeral Service Lio-ns 22. Name and Address of Facility Evans Funeral 8800 Harford l Chapel & Cremation Services
Road Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final inset and Death Pnysician/ Vrosepsis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ed by the a detached f ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WSPI 2 No ျပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29b. Signatup ess of person who completed cause of death (Item 23a) (Type, Print) HAWES Date filed (Month, Day 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b Per FH G929 //13/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Howara July 6:34 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death Examiner imore indale Home 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days $m \nu$ Director Usual Residence of Decedent City, Town or Location 10d. Inside City Limits 10a, State 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified</u> at 1 ☐ Yes 2 ☑ No Director timore TOWN filed within 72 hours after death with the Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other transment. ineci 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/3-0 X 19a. Informant's Name/Relationship (Type. Print) erdell MOL 20b. Place ceme 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4 US 21 Signature of Funeral Service Licensee 728 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 min. Physician Acute Cardiac event /Medical Due to (or as a consequence of): Examiner artery year COYONAYY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-trar and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 å Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funeral Director: the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier gun, MD D0053928 07-11-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BECZUM, MD 2434 WIBELVEDERE AVENUE, BALTIMORE, MD - 21215 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ P^{M} 2012 Walter Albert Houchens July Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince George's Hyattsville 3803 Oliver St. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5 Social Security Number . Age (In yrs. last birthday) **Funeral** 75 Director 577-48-7736 1 🕱 M 2 🗆 F Yrs Oct. 14, 1936 Washington, DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Prince George's Hyattsville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20782 3803 Oliver St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, n "natural", or item edical Examiner n 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates. Army Page 1 and 2 should be filed within 72 noons thent of Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Maintenance Supervisor Law Firm Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Marshall Williams George Hamilton Houchens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains Hyattsville, MD 20782 Elizabeth D. Houchens /Spouse 3803 Oliver St.. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Veterans Cemetery 17/17/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral S Bowie, MD 6512 NW Crain Hwy., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vear Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events that the death certificate be executed and trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown COPD Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed death? 1 Yes 2 No certificate Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum_{\text{Nursing Home}}\) 5 \(\frac{\text{X}}{\text{Residence}}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1 X Natural 5 \square Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Belcrest Road <u>Hvattsville.</u> <u>Dr. Ellen D. Finkelman</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G929 //13/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0.7 Marion Helsel 07 2012 6:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8351 Dubbs Drive Anne Arundel Severn Social Security Number If Under 24 Hrs Hours Min. **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 173-14-4196 1 X M 2 □ F 91 06/04/1921 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo FL. Pinellas Saint Petersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 5809 4th Ave N 33710 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? XX Yes 2 □ No If Yes, Give "natural", or item edical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: XX Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Conductor Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Charles Helsel Pear1 Koofer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jarrett / Daughter 8351 Dubbs Drive Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 7/10/2012 Glen Burnie, MD 21. Signatur 22. Name and Address of Facility Singleton Funeral & Cremation Þ Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a, Part 1. Enter the disease of escaplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to (or as a consequence of) attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year signed by the and do not be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Hospital 2 No Other: 4 \(\text{Nursing Home} \) \(\text{Specify} \) Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Directors,
completely filled in by the 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number State

H DHMH 17 Rev 06-2011

Registrar

DHMH 17 Rev 1/2001

State

Registrar

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N NA EEM.

AMATUN

31. Date filed (Month Day, Year) - -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Month 12:12AM **Physician** June 28 Edison Mitchell Hughes, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL ALTIMORE ST AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 X M 2 □ F 92 Maryland 1920 April 4. Director 705-14-1193 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10h County an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 Yes X No Elkridge Maryland Howard Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21075 6668 Athol Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ₩idowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) B.O. Railroad <u>Secretary</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Mae Bender Edison Mitchell Hughes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5801 Meco Drive, Sykesville, Maryland 21784 Diane Martinez - Niece 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Mem. Park 07/02/2012 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Funeral Service Lice 7250 Washington Blvd., Elkridge, Maryland 21075 inu M01283 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist hij one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumothorax dayo **Physician** /Medical Due to (or as a consequence of): Examiner Thabdomyolosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ARTERY DISEASE for use as the burial-transit Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 pertension Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) HWGHES, EDISON 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an autopsy 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after dear To the Funeral Pirector completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 28, 2012 120069177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave Baltimore MD 21229 Valikhani Mohamm 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 3 2012 Registrar Ener S. Jake

DHMH 17 Rev 1/2001

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| Larry Mark Hiltor | 1 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| arry wilders raises. | 1- For State Registrar | to or maryiana / 1 | Certificat | e of De | ath | | 7,5 | Reg. | No. 2 | | 2 2215 |
|--|---|---|--------------------|---------------|------------------|---------------------|------------------------------------|--------------------------|------------------------------|--------------|--|
| Physician | Decedent's Name (First, Middle, | 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year | | | | | | | 3. Time of Death 2144 hrs | | |
| Medical Examine | Larry Ma 4a. Facility Name (if not institution, | ark Hilton | | 4b. Ci | ty, Town, or Lo | ocation of I | | 4, 2012 | 4c. County of | f Death | |
| | 6673 Pirch Way | 3.1.2 • 1.1.2.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1 | | | kridge | | | | Howard | | |
| Funeral | Social Security Number 6 | . Sex 7. Age (I | n yrs. last birthd | | Inder 1 Year | If Under 2 Hours | 24Hrs. 8. Da Min. | te of Birth(| MM/DD/YYYY) | Foreign | place (State or |
| Director | 214-58-7837 | 1XM 2 F 58 Yrs. World's Says 13613 Wall 1953 | | | | | | 953 | Cour | ntry)MD | |
| Any | Usual Residence of Decedent 10a, State 10b. County | 10 | c. City, Town or | Location | | · · · · | | | | | 10d. Inside City Limits |
| | . MD Howard | d I | | | | E | lkridg | e | | | 1 XXYes 2 No |
| n nr 28a-f show tified at once. | 10e. Street and Number | | | 10f. | Zip Code | | | 10g. | Citizen of Wha | at Count | ry? |
| th the Maryland 23a nr 28a-f sho notified at once | | | | | | 1075 | | | United | | |
| r death with or items 23 | 11. Marital Status 1 Never Married 2 Man | 12. Was Decedent Ev | er in U.S. 1 | | | | n? (Specify Ye Puerto Rican, e | | 14. Race - White | | an Indian, Black, |
| | | 1 Yes 2 7 | | 1 Yes | 2 x x No | specify: | | | Specify: | | |
| 5-0036 led within 72 hours after atygiene after than "astural", the Medical Examiner | 15 Decedent's Education (Specif | or Dates: | | | sual Occupation | | nd of work dor | ne 1 | 6b. Kind of Bus | siness/In | dustry |
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| OO3 within giene. | 17. Father's Name (First, Middle, L | ast) | | Owner | /Opera | tor 3.Mother's | Name (First, I | Middle, Ma | iden Surname) | | Company |
| 21215-0036 Juld be filed within 7 Mental Hygiene, marked uther than ic event, the Medica | | | | | | Gert | rude F | rance | s Pfis | ter | |
| ID 21; should the and Men (7 is mar natice) | 19a. Informant's Name/Relationshi | | | | | | | | er, City or Town | | |
| alth | Timothy D. Hil | ton - brother | 20b. Place of I | | | | Date | | Marylaı 20c. Location - | | |
| Ore ges l a t of He ither t | 1 Burial 2 XXCremation | | | y or other pl | | | 07-00- | 2012 | Clan | Dann | d _M or |
| Baltimore, permit. Pages 1 a Department of He Important: If its injury an ather t | 4 Donation 5 Other Spe 21 Signature of Funeral Service L | | Attant | 22. Name | emator | y of Facility | Gary L | . Kau | Glen l ıfman Fı | uner | al Home at |
| Depril Inju | Mark M. S | Haw | | MMP, | Inc, 7: | 250 W | Vash. B | lvd., | Elkri | dge, | MD 21075 |
| Physician | 23a. Part I. Enter the disease, or clearly one cause of | omplications that caused the n each line. | death. Do not | enter the mo | ode of dying, s | uch as car | rdiac or respira | atory arrest | t, shock, or hea | ırt | Approximate Interval Between Onset and |
| /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | a. Cirrhosis (| | | | | | | | | Death |
| | Sequentially list conditions, | b. Chronic Al | | m | | | | | | | |
| | | Due to (or as a consequ | ence of): | | | | | | | | |
| red nisit | (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequ | ence of): | | | | | | | | |
| 760, cate be executed physician and he burial - transit | | d | 27 nei | - me o | 929 7- | 24-12 |) em | | | | |
| 60, ate be executhly sician and the burial - tra | IF FEMALE: | 23c. If yes, outcome | | шсуд | | | - JIII | _ | 23d. Date of | delivery | |
| 687(ertifica | | | 2 [| Fetal de | _ | Ectopic | pregnancy | | Month | Da | ay Year |
|). Box 687 the death certification by the attending plented for use as the box of the deferment of the defer | 1 Yes 2 No 9 Unkr | - L | ne of death 5 | Other (| (Specify) | | | _ | | | |
| O. E at the c d by th | | ons contributing to death b | ut not resulting i | n the under | lying cause gi | ven in Parl | | | | _ | he cause of death? |
| P.C. iries that signed d be deta | | | | | | | | Yes la. Was an | | | ably 4 ✔ Unknown opsy findings available |
| aw requires has been sig | | | | | | | _ ' | autopsy perform | , p | | ompletion of cause of |
| tal Rec | | | | | 00 Pl | -f Dth // | 1 Check only on | ✓ Yes 2 | | ✓ Yes | s 2 No |
| Vital Recysician: The Libit certificate I director, page | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient | 2 ER/Out | patient 3 | | | Nursing Home | | esidence 6 | Other: | Scene |
| of Ving Physical directions of the control of the c | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury (Month, Day,Yea | | me of Injury | 28c. Injury | y at Work? | 28d. D | escribe ho | w injury occurr | ed | |
| ion tendir leath. for: A | 1 X Natural 5 Pendi 2 Accident Invest | ng igation | | | | es 2 l | - | | | | |
| Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfer of the control of the contro | 3 Suicide 6 Could | not be nined (Specify) | y - At home, fari | m, street, fa | ctory, office bu | uilding, etc | | cation (Str Town, Sta | | er or Rur | al Route Number, City |
| Divis To the Hospital or A within 24 hours after completely filled in b | | ysician: To the best of my i | nowledge, deat | h occurred a | at the time, dat | te and plac | ce, and due to | the cause | (s) and manner | as state | ed . |
| To the F To the F complete | (Check only one) 2 Medical Exam | niner: On the basis of exami | nation and/or inv | estigation, | in my opinion, | death occ | curred at the tir | ne, date ar | nd place, and d | ue to the | e cause(s) |
| ESES | | | - | | 29c. License | | | | 29d. Date sign | | th, Day, Year) |
| | high | | | | O.C.N | л. С. | | | July 5, 201 | | |
| | 30. Name and address of person value Ling Li, MD Assistar | who completed cause of dea nt Medical Examiner | | Itimore S | treet, Balti | more, N | /ID 21223 | | | | |
| Sta | | 32. Registrar's | | | | | | | | | |
| Registra | JUL 1 3 20 | 12 Janua | 1. 1 | action | , | | | | | | |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ Fred Harvev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3810 Monterey Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 214-40-7345 1 🖵 M 2 🗆 F Director VA. Oct.14,1928 83 Usual Residence of Decedent 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore MD 1 X Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21218 USA 3810 Monterey Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Sanitation other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Harvey Doug Elam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3810 Monterey Rd. Balto,Md. 21218 Emma Green (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. July 17,2012 Balto, Md. Zion Cem. ²² Name and Address of Facility Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Lic 412 E St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final NA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) [/]Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi is certificale has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CHE 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 5 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 1 Natural 2 Accident 5 🗌 Pending Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

4:40 pm

Harvey 7/10/12

Fred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 17:20 PM KETTH HAYES JULY 2012 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE MEDSTAR HARBOR HOSPITAL N/A If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Feb 2, 1957 Days MD Country Months Hours Min. 1 🕱 M 2 🗆 F 214-62-9329 Director 55 Usual Residence of Decedent 28a-f shov 10b. Count 10c. City. Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore Baltimore 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10090 Mill Run Cir. 425D 21117 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married φ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifBlack Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Duron Paint permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Şeconday (0-12) 12th $\overset{\text{College (1-4 or 5+)}}{N/A}$ Warehouse Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

John Royal Hayes Eula Mae Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 10090 Mill Run Cir. 425D Owings 19a. Informant's Name/Relationship (Type, Prin te, Zip Code) Mills, Derek Hayes, Sr / 1117 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Garrison Forest Va 7/18/12 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 6 gnatura meral Service Lice 2700 Edmondson Ave. Balto., MD 21223 ker Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ SEPTIC SHOCK DAY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DAY PNEUMONIA Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown HIV, HEPATITIS B. CHRONIC KIDNEY Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DISEASE, SLEEP APNEA, OPIATE DEPENDANCE autopsy perform death?
1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 XNo 1 Impatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending М Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

the

3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225 VISHAL VASAVADA 31. Date filed (Month, Day, Year)

JUL 1 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifie

2. Registrar's Sign

mD

State

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RES 001

29d. Date signed (Month, Day, Year)

10

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a Pt. I per phy, 9929 7-13-12 sm.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Herbert Gerhard Janssen 9:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rock Spring Village Forest Hill Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 071-12-5025 Director 1 ★M 2 ☐ F 89 July 8, 1922 Germany Usual Residence of Deced ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10f. Zip Code 10q. Citizen of What Country? 2017 Hanson Road 21040 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White "natural", 3 ₩idowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Military U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I ပ Edward Herman Janssen Gesina (nmn) Pryet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 Bailey Road, Forest Hill, MD 21050 Karen A. Janssen / Daughter 1 and 2 s if Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ŏ Department of Important: If it any injury or o ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 8-7-2012 Arlington Nat'L Cem. Arlington, Virginia ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ culine +. They Medical Due to (or as a consequence of) Examiner Renal Disease Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year by the Unknown Part II. **Other significant conditions co**ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 \sum No page 2 2√□ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 2 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D35522 301710.202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive, Bel Air, MD 21015 31. Date filed (Month, Day, Year) State 3 2012 Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | 4 | For State of Maryland | | tment of He ificate of De | | | <u></u> | 012 22155 |
|----------------------------|---|---------------------------|--|-----------------------------------|--|--------------------------------|----------------------------------|------------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | Certi | incate of Di | Catti | 2. Date of Deat | eg. No. h | 3. Time of Death |
| н | Physicia | n/ | Lillian D Kess July 8 | | | | | | Year 2012 11 55 P M |
| and the last | Medic Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or L | ocation of Death | | 4c. County | |
| man de | | | Carroll Hospital Center. | | Westmi | | | | irroll |
| 12 | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last | 1 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | Year) | Birthplace (State or Foreign Country) |
| | Director | | 241 – 32 – 6389 | Yrs. | | | 06/17/ | 1924 | N.Carolina |
| | and show | jo | 10a. State 10b. County 10c. City, | , Town or Loca | | | | | 10d. Inside City Limits |
| | Maryl 28a-f otified | Director | Maryland Baltimore Rei | sters | | | | | 1 Yes 2X No |
| | h the | | 10e. Street and Number | | 10f. Zip Code 21136 | | | 10g. Citizen of USA | What Country? |
| | 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at | Funeral | 302 Cantata Court #206 | 13 W | as Decedent of His | spanic Origin? (Spe | cify Yes or No- | | ce - American Indian, |
| ·0 | or ite | by Fu | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No | If Y | Yes, specify Cuban | , Mexican, Puerto I | Rican, etc.) | Bla | ack, White, etc. |
| 21215-0036 | iral", | ed b | 3 | 11 | ☐ Yes 2X No | Specify: | | Specify | Black Black |
| 5-0 | 2 hou "natu edical | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give kir | | tion uring most of worki | ng | 16b. Kind of E | Business/Industry |
| 121 | within 7; giene. ner than t, the Me | E I | Elementary/Secondary (0-12) College (1-4 or 5+) | | NOT use retired) c Healt | h Assis | tant | Baltir | more City |
| | 0 - | Be (| 12th grade 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | Maiden Surnan | ne) |
| Maryland | should be filed and Mental Hy 7 is marked oth raumatic event | 은 | Ulysee Jackson | | | Frances | Willi | ams | |
| ary | should and N is ma | | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | Address (Street a | nd Number or Rura | l Route Number, | City or Town, | State, Zip Code) |
| Σ | nd 2 sealth m 27 ner tra | | | | | | | | MD 20744 |
| ore | ye 1a It of H If ite or oth | | 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State | lace of Disposi emetery, crema | atory or other place | 07/1 | 6/12 | | l, Maryland |
| Baltimore, | it. Pag irtmen irtant: irjury | | 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee | - | Nat 1 | Cemeter | У | | s Funeral Home |
| Ba | permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. | | wellen Harr | 52 | 40 Reis | terstow | n Rd.B | altimo | ore MD.21215 |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. | . Do not enter | the mode of dying | g, such as cardiac o | or respiratory arre | est, | Approximate Interval Between |
| F | hysician/ | 9 A | Immediate Cause (Final disease or condition | λ | | | | | Onset and Death |
| | Medical Examiner | | resulting in death) Due to (or as a conseque | | | | | | |
| | | er | Sequentially list conditions, b. Silenteral | ence of: | o Hulla | ns | | | |
| | nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | nulian | e | | | | |
| | execut in and ial-tra | Exa | that initiated events resulting in death) Last C. Due to (or as a consequence of the cons | ence of): | 4 | | | | |
| 09 | ate be executed ohysician and the burial-transit | dical | d | | | | | | |
| 687 | rtificat ing ph e as th | /Med | IF FEMALE: 23c, If yes, outcome of pregnan | ncv | | | | 224 [| Date of delivery |
| Вох 6 | requires that the death certifica been signed by the attending ph should be detached for use as t | Completed by Physician/Me | in the past 12 months? | al death 3 🔲 | Ectopic pregnanc Other (specify) | У | | 1 | Nonth Day Year |
| Ğ. | re dez | ysid | 1 Yes 2 No 4 Pregnant at time of do 9 Unknown 9 Unknown | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | |
| P.O. | that the | y P | Part II. Other significant conditions contributing to death but not result | | | | | | ntribute to the cause of death? |
| S, | puires en sign | ed b | Hypertensian, Peripheral Vascu | lar du | esc., Coro | ung | 1 🗆 ` | | 3 Probably 4 Unknown |
| Sor | w red as bee 2 sho | plet | Avery disease MI 1975, dusph | agia, | decorreli | tioning | 24a. Was autor | sv | Were autopsy findings available prior to completion of cause of death? |
| Rec | The la | S | | | | | | rmed? 2 No | 1 Yes 2 No |
| ta | cian: certific ector, | Be | 25. Was case referred to medical examiner? | | _ Othe | ace of Death (Chec er: | | | |
| Ϋ́ | Physic this caral direction | 2 | | 28b. Time of | 28c, Injury | 4 □ Nursing Ho y at | ome 5 L Resid 28d. Describe h | | |
| o u | th. : After e fune | cate | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | injury | M 1 🗆 | :? Yes 2 🗆 No | | | |
| Division of Vital Records, | er dea ector by th | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify) | ome, farm, stre | eet, factory, office | | 28f. Location (S City or Tow | | nber or Rural Route Number, |
| <u>S</u> . | ital or irs aftu al Dir | a C | | | | | | | anney en atatad |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic. | Medical | 29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowle on the control of the control of the certifying Nurse Practitioner: To the best of my knowle of the certifying Nurse Practitioner: To the best of my knowle of the certifying Nurse Practitioner: To the best of my knowle of the certifying Nurse Practitioner: To the best of my knowle of the certifying Nurse Practitioner: To the best of my knowle of the certifying Physician: To the best of my knowle of the certification of th | n and/or investi | igation in my opinic | on, death occurred a | it the time, date a | and place, and c | due to the cause(s) and manner stated. |
| | Fo the vithin To the comple | Σ | only one) 3 L Certifying Nurse Practitioner: lo the best of m 29b. Signature and title of certifier | ny Knowledge, | 29c. License | | | | ned (Month, Day, Year) |
| 0 | ->=º | | MA MA | | D | 69086 | | July | 8 2012 |
| | .0 / | | 30. Name and address of person who completed cause of death (Item | | | | -> | _ | |
| | 101 | | | | plat Cent | er, worth | uniler t | 10 2 | 1157. |
| | Sta Registi | | 31. Date filed (Month, Da), Year) 32. Registrar's Signat | ture | | | | | |
| | | | 1111 11 (11 (11 (11 (11 (11 (11 (11 (11 | -01 10 | THE STATE OF THE S | | | | |

| | | 1 | For State Registrar | State of Mary | | tificate of D | | | Reg. No. | | |
|--|----------------|-----------------|--|--|---------------------|--|--------------------------------|-------------------------------|--------------------------------------|--|--|
| Physic | cian | _ | I. Decedent's Name (First, Middle, Last |) | | | | 2. Date of Dea Month | July 9, 20 | 3. Time of Death 6:45 RM | |
| | dica | ١, | Helen Krute a. Facility Name (if not institution, give s | street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of D | | |
| <i>i</i> | Į | | | Milford Manor Nursing Home cial Security Number 6. Sex , 7. Age (In yrs. last birthday) | | | | ore 8. Date of Birt | N/A | Birthplace (State or Foreign | |
| Funer Directo | _ | 5 | 6. Security Number 012-22-8446 | M 2 KF | 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Da | , 10°, 1928 | Country) Massachusetts | |
| nd how | ٦, | | Usual Residence of Decedent 10a, State 10b. County | 10c. | . City, Town or Lo | cation | | - | | 10d. Inside City Limits | |
| Marylar 8a-f s | | Director | MD Balti | more | Pikesv | ille | | | | 1 Tes 2 XNo | |
| th the l 3a or 2 t be no | | | Oe. Street and Number 4204 Old Milfor | d Will Dd | | 10f. Zip Code 2120 | 18 | | 10g. Citizen of What | Country? States | |
| eath wi | | Funeral | 1. Marital Status | 12. Was Decedent Ever in Armed Forces? | ı U.S. 13. \ | Was Decedent of Hi f Yes, specify Cubar | | cify Yes or No- | 14. Race - A | merican Indian, | |
| should be filed within 72 hours after death with the Maryland sand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at | | ≥ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏞 Divorced | 1 Yes 2 No If Yes, Give Year or Dates. | | 1 Yes 2 No | | illouit, otoly | Specify: | white White | |
| 72 hour "natu edical | | Completed | 15. Decedent's Ed (Specify only highest gra | | (Give | dent's Usual Occupa kind of work done o O NOT use retired) | ation Juring most of worki | ng | 16b. Kind of Busine | ess Industry | |
| within jiene. | | | Elementary/Seconday (0-12) | College (1-4 or 5+) | | itor | | | Public | : Relations | |
| should be filed within and Mental Hygiene. is marked other tha aumatic event, the N | 1 | o Be | 17. Father's Name (First, Middle, Last) Bernard Vernon | | | | 18. Mother's Name | e (First, Middle, brams Co | | | |
| 1 c, INICI JIC 1 and 2 should be of Health and Men item 27 is marke other traumatic | | Ī | 19a. Informant's Name/Relationship <i>(Ty</i> | | | ng Address (Street & | | | er, City or Town, State, | Zip Code) | |
| | | 1 | 20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State | | osition (Name of matory or other place | e) | Jul 12 2012 | 20c. Location - City , Beltsv: | or Town, State | |
| permit. Page Department of Important: If any injury or | once. | | 21. Signature of Funeral Service Licens | | | 2. Name and Addres Crematio | ss of Facility on and Fun | eral Ali | ternatives | ryland 21286 | |
| | | \dashv | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or | plications that caused the | death. Do not ent | er the mode of dyin | rest, | Approximate Interval Between | | | |
| Physicia | 2002 | | Immediate Cause (Final disease or condition resulting in death) | | nsons | Didla | el | | | Onset and Death | |
| Medic Examin | | | Immediate Cause (Final disease or condition resulting in death) Parkins ons Didladl Due to (or as a consequence of): Failure to Thome | | | | | | | | |
| 7 # | 4 | Juer | Sequentially list conditions, If any, loading to introduct cause. Enter Underlying Cause (Disease or linjury | | | | | | | s.b. | |
| cate be executed physician and sthe burial-transi | | edical Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Due to (or as a con | sequence of): | | | - | | | |
| ate be e | | dical | | d | | | | | <u> </u> | | |
| ath certifi attending for use a | | Σ | | | | | | | 23d. Date o Month | f delivery Day Year | |
| requires that the destream signed by the should be detached | | 2 | Part II. Other significant conditions of | ontributing to death but no | ot resulting in the | underlying cause gi | ven in Part I. | 23e. Did t | | e to the cause of death? | |
| Notal Records, Physician: The law requires r this certificate has been signal director, page 2 should b | | Completed | | | | | | | ppsy prior deat | e autopsy findings available to completion of cause of h? Yes 2 \sum No | |
| cian: T cian: T ertifica ector, p | | | 25. Was case referred to medical examiner? | Hospital: | | 26. P | ace of Death (Chec | k only one) | | | |
| Physic rthis c | | <u>و</u> ن | 1 Yes No | 1 Inpatient 28a. Date of injury | 2 ER/Outpatie | of 28c. Injur | y at | | idence 6 Other (S | pecify) | |
| on c ending eath. or: Afte he fune | | Certificate: | Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b | | | | Yes 2 No | | | | |
| DIVISION OF TAIL OF TA | | | 4 Homicide determined | 28e. Place of Injury - building, etc. (Sp. | | reet, factory, office | | 28f. Location (City or To | Street and Number of wn, State) | Rural Route Number, | |
| DIVISION OF VITAL MEN To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page | | edical | (Cheek 2 Medical Exam | sician: To the best of my kiner: On the basis of examine Practioner: To the best | | | | | | | |
| To the within | | Σ | 29b. Signature and title of certifier | A 2- | | 29c. Licens | e number | | 29d. Date signed (M | fonth, Day, Year) | |
| 6 | | | 30. Name and address of person who | completed cause of death | (Item 23a) (Type, | Print) | 12536 | 1 - | 1-11 | nove mp | |
| り | | | SUMIT BYUTA | N1 82 | 21 NEU | tow Shre | el Due | 4 30 D | 15ally | nore in | |
| Regi | State istra | | 31. Date filed (Month, Day, Year) JUL 1 3 201 | 2 82. Hegistrar's S | d. San | Kal | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#20b, perFH, G929, 7/23/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15:54 M KNIGHT 10 LRVIN 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL Baltimore HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 213-80-9162 Director 1 **X** M 2 □ F 01-08-28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Yes 2 🗆 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a USA Forest 21207 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) e Construction College (1-4 or 5+) DNSTRUCTION Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ lertha ichardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother 65 IGHWAY Method of Disposition 20b. Place of Disposition (Name of WNIC 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place, Baltimore, MD 4 Donation 5 Other (Specify) Druid Ridge 22. Name and Address of Facility VAU 5+th GREENE FUNERAL SCVS of Juneral Ser Baltimore, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examine Due to (or as a consequence of): and the burial-trai Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Yes Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural iniury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 2012 son who completed cause of death (Item 23a) (Type, Print) 201E UNIVERSIT RIZQUI 32. Registrar's Signatu State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G934 12/07/2012 JH State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20<u>12</u> Physician/ $Ju1v^{Month}$ Year Tu Hvon Kim 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9701 Bolton St. Laurel Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 3203 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 239-29-2395 Director 1 X M 2 🗆 F 72 Mar. 22, 1940 South Korea Usual Residence of Decedent show 10a, State 10c. City, Town or Location must be notified at Director 28a-f 1 Yes 2 X No MD Howard Laurel o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9701 Bolton St. 20723 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Asian Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Dry Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jum-Nae Won Gil Sung Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Bolton St., Susie Kim / Spouse Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Mem. Gardens 17/14/2012 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ TANIKEATIC CANITA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ascites Jaun Zicp 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: 1 Tes ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2' Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30573 7-12-12 Dr. #6020 Colymbia Md. 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 10710 Charter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 2012 Physician/ JULY 3:00 A.M MARK A. KLAUSLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE LORIEN MAYS CHAPEL NURSING & REH. TIMONIUM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2 □ F Days Hours Min 94 Director NORTH DAKOTA /30/1918 <u>470-18-1708</u> Usual Residence of Decedent 10b. County 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State **Funeral Director** or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo RUXTON MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a 27 RUXVIEW COURT USA APT. 202 21204 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) FINANCE YEARS DEPARTMENT HEAD Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 amanda HUNZIKER JOSEPH P. KLAUSLER .. Page 1 and 2 should b tment of Health and Mer tant; If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 RUXLEA COURT BALTIMORE, MD KAREN HALPERT/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY, INC. 7/11/2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, TOWSON, MD 21286 8521 LOCH RAVEN BLVD. 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death -Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ENDO CARDITIS Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sequence in death). Examiner Due to for as a nonsequence of: AFIB Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes Accident Investigation s after death | Director: A 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson mi 701 CHARLES 51 SIE 4105 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ KOLPACK DONALD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice Northwest Hospital Center -Baltimore Randallstown Wing 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days (Month, Day, Year) Hours **Director** 215-70-3499 1 X M 2 | F 56 09-15-1955 Maryland Usual Residence of Deceden ed other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at end 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Str. for marked outher than "natural", or items 23e or 28e-f sho item 75 marked outher than "natural", or items 23e or 28e-f sho ither traumetic event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No MD Columbia () Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9580 Glen Oaks Lane 21046 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Construction Carpenter æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Pierpont Kolpack Patricia Jane Whipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela L. Snowden - sister 9580 Glen Oaks Lane, Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Importent: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Prk. 07-06-2012 4 ☐ Donation 15 ☐ Other (Specify) Elkridge, Maryland 21. Signature 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 E Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the a should be detached 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of death (Item 23) (Type, Print) 31. Date filed (Month, L State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 545 AM Physician/ 2012 Margaret Ruth Lester 14/4 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Be Healthand Rehabilation Cen 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 1 □ M 2 🛚 F **Director** 217-38-4184 12/07/1942 Maryland 69 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2X No Kingsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21087 U.S.A. 11703 Cedar Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Medical Examiner Armed Forces? 1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaking Own Home other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Monta Important: If item 27 is marked any injury or Although မ Linwood S. Belt Ruth Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 11703 Cedar Lane - Kingsville, Maryland 21087</u> Joe A. Lester (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 07/16/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) ____ Day Month Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 \sum Yes Other: 2 No 20 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No

Maryland 21215-0036 Baltimore, ルメート しとんし Division of Vital Records, P.O. Box 68760 To the Funeral Director: After this Medical Certificate: Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined hours after 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse practitioner: To the best of my know 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D 0063981 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) ŊV Havrede Grace, MD 37. Revolution State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 201.2 Physician/ Month Jully 4:35PMM Sara Onsel Sherrer Leizear Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore County Cockeysville Broadmead Retirement Community 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** (Month Day, Ye Days Months Min Country) Ohio 1 □ M 2 🛛 F 80 Jäñ Director 280-32-3814 Usual Residence of Decedent show 10d, Inside City Limits 10b County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Cockeysville Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21030 USA 13801 York Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laurel Bonawit Edward Joseph Onsel, 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 Monkton Road, Monkton, Maryland 21111 Curtis E. Sherrer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/2012 Catonsville, Maryland Metro Crematory, Inc. Signatura of Fundal Service Luca see 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC
6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -well disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23d Date of delivery 23b. Was decedent pregpant Live Birth 2 Fetal death Pregnant at time of death 3 Fctopic pregnancy in the past 12 month Month ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 🗌 Yes 3 Probably 4 Unknown of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 \(\text{Yes} \) within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 26. Place of Deathy(Check only one) Be 25. Was case referred to medical examiner?

1 Yes 2 12 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Watural the Hospital or Attending injury 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 5 31. Date filed (Month, Day, Year) 32. Registre State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | State of Maryland / Dep | | Mental Hygiene | 0 | | |
|--------------------------------|---|----------------|---|--|---|---------|--|--|
| | | _1 | negistrar | ertificate of Death | Reg. No. 2 () 2 22 0 |)) | | |
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year July 10, 2012 3. Time of Death 5:15 A. | | | | |
| | Medic | al . | Mary Annita Link | 4. City Taylor and acetion of Dooth | July 10, 2012 5:15 A. 4c. County of Death | M | | |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) Maria Health Care Center | 4b. City, Town, or Location of Death Baltimore | Baltimore | | | |
| | Funeral | (cl | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) |) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreig | gn | | |
| | Director | | 217-18-1352 1 □ M 2 N F 89 Yrs. | Months Days Hours Min. | (Month, Day, Year) Country) Feb. 9, 1923 Maryland | | | |
| | land show d at | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L | | 10d. Inside City Limit | ts | | |
| | ryland I-f sh Ied a | 당 | | imore | 1 ☐ Yes 2 🔯 I | | | |
| | r 28a notif | Dire | Maryland Baltimore Balt | 10f. Zip Code | 10g. Citizen of What Country? | | | |
| | vith th | ıral | 6401 N. Charles Street | 21212 | U.S.A. | | | |
| | eath v | Funeral | | B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto | | | | |
| 9 | fter d | by | 1 X Never Married 2 Married 1 Yes 2 X No | 1 Yes 2 X No Specify: | Diagni, Trinte, etc. | | | |
| 00 | turs ar | Completed | 3 Wildowed 4 Divorced Year or Dates. | | Specify: White | | | |
| 15- | 72 hc n "na Nedic | ldu. | (Specify only highest grade completed) (Giv | cedent's Usual Occupation re kind of work done during most of work DO NOT use retired) | ding 16b. Kind of Business/Industry | | | |
| 212 | within giene. sr tha the N | | Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years | Educator | Education | | | |
| bd | al Hyg | | 17. Father's Name (First, Middle, Last) | 18. Mother's Nam | ne (First, Middle, Maiden Surname) | | | |
| ylai | ld be Ment arke | 유 | John Link | Margar | | _ | | |
| Nar | shou rand | - 1 | | | ral Route Number, City or Town, State, Zip Code) | - 1 | | |
| e, l | and 2 Health em 2 ther t | - 3 | Sr. Bernice Feilinger, S.S.N.D. 640 20a. Method of Disposition 20b. Place of Dis | | Date 20c. Location - City or Town, State | - | | |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at ance. | | 1 X Burial 2 Cremation 3 Removal from State cemetery, cr | rematory or other place) | 7-12 Glen Arm, Maryland | | | |
| Ħ | nit. Partme ortan injur | li | | | | \neg | | |
| B | Depar Depar Impor any ir | - 1 | I Joseph Flynn | Mitchell-Wiedefeld 6500 York Road B | Funeral Home, Inc. 21212 | | | |
| | | | 23a. Part 1. Exer the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. | nter the mode of dying, such as cardiac | or respiratory arrest, Approximate Interval Between | | | |
| -1 | tiyulcian/ | | Immediate Cause (Final disease or condition | al Interdim | Onset and Death | | | |
| | Medical Examiner | | resulting in death) Due to (or as a consequence of): | - | | | | |
| | <u> </u> | ra e | Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): | edisma | | | | |
| | ed ed | i i | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 1100 017-1 | | | | |
| 1/0 | xectit | Exa | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | | |
| 09 | ate be executed hysician and the burial-transit | dical Examiner | d | | | | | |
| 9289 | ificate g phy as th | Med | IF FEMALE: | | | \neg | | |
| 9 × | requires that the death certifica been signed by the attending pl should be detached for use as t | Physician/Me | 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 | | 23d. Date of delivery Month Day Year | Ì | | |
| Box | deat the at hed fo | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown | 5 Other (specify) | World Say | | | |
| P.O. | at the | | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? | - 1 | | |
| S, T | signe d be | d by | | | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkno | own | | |
| puc | been shoul | Completed | | | 24a. Was an 24b. Were autopsy findings availab | | | |
| ec | re law te has age 2 | Juo | | | autopsy prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No | , | | |
| al F | sician: The certificate irector, pag | l o | 25. Was case referred to medical | 26. Place of Death (Chec | | | | |
| Zit | nysici nis cel I direc | 70 B | examiner? 1 | | lome 5 Residence 6 Other (Specify) | | | |
| 1 of | ding Phys h. After this funeral di | | 27. Marter of Death Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury | y work? | 28d. Describe how injury occurred | | | |
| ion | ttendideath death tor: A | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Discription 28e. Place of Injury - At home, farm, | M 1 Yes 2 No | 28f. Location (Street and Number or Rural Route Number, | | | |
| Division of Vital Records, | after Direc | | 4 Homicide determined building, etc. (Specify) | Street, factory, office | City or Town, State) | Į. | | |
| | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it. | Medical | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea | th occurred at the time, date and place, a | and due to the cause(s) and manner as stated. | tatad | | |
| | he Ho in 24 he Fu pletel | Med | (Check 2 ☐ Medical Examiner: On the basis of examination and/or into only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowled | vestigation, in my opinion, death occurred a dige, death occurred at the time, date and p | | stated. | | |
| | with To the | | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) | | | |
| | | | Med IV Howalandhing Wall | y Dogger | 13 1091112012 | | | |
| - | / | | 30. Name and address of person who completed cause of death (Item 23a) (Type | e, Print) 125, Paltimo | re mix alany | | | |
| | Sta | te | 31. Date filed (Month Day Year) 32. Registrar's Signature | - GOLLINIO | TO NOT | | | |
| | Registr | | 31. Date filed (Month Day, Year) 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2012 7:30 A.M Earle Walter Little Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Edgewood 1901 Steven Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year, Director 218-34-1915 1 🔀 M 2 🗆 F 74 Nov. 17, 1937 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Harford Edgewood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with in Department of Health and Mental Hygiene. In term 27 is marked other than "natural", or items 23a any injury or other traumatic event the Maction 1 Funeral USA 1901 Steven Drive 21040 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 XWidowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Firefighter U.S. Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Little Latka Earle Walter Little Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Morrow / Niece 585 Kirkcaldy Way, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 E Burial 2 Cremation 3 Removal from State Bel Air Memorial Gdn: 7/13/2012 | Bel Air, Maryland 4 Donation 5 Other (Specify) Streture of Funeral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Directly for an a non-negation is by attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) ed by the a detached 1 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 3 Probably 1 Yes 2 No Completed peen 24b. Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be 1 Yes 20 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?

1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Investigation Accident after deat filled in by the 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Funeral Medical 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

DHMH 17 Rev 06-2011

State

only one) 29b. Signature and title of certifie

poleted cause of deat

32. Registra

29c. License numbe

da Gaco, MD 2107-8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State of Maryla | | artment of I | | | 211 | 12 | 22165 |
|---------------------|--|--------------|--|---------------------|---------------------------------------|--|---------------------------------|-------------------------------|----------------------|-------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | 001 | tinoute of E | Journ | 2. Date of Dea | Reg. No. | | 3. Time of Death |
| | Physicia | | Virginia Dare Lemly | | | | July 1 | | Year | 10:15 A M |
| | Medio Examin | | 4a. Facility Name (if not institution, give street and number) | | 4b. City. Town. o | r Location of Death | l cary | 4c. County | of Death | 10.13 11 |
| لحريب | | | 276 Wakely Terrace | | Bel Air | | | Harfo | | |
| | Funeral | | | . last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da | | 9. Birthpl Countr | ace (State or Foreign |
| | Director | | 246-28-1533 1□M25xF 88 | Yrs. | World is Days | Flours Willi. | Feb. 8 | | | Carolina |
| | nd how at | 'n | Usual Residence of Decedent 10a. State 10b. County 10c. 0 | City, Town or Lo | cation | | | | | d. Inside City Limits |
| | laryla 3a-f s ified | Director | Maryland Harford I | Bel Air | | | | | | 1 ☐ Yes 2 🔀 No |
| | or 28 | Dir | 10e. Street and Number | <u> </u> | 10f. Zip Code | | | 10g. Citizen of W | hat Count | ry? |
| | with s 23a ust b | Funeral | 276 Wakely Terrace | | 21014 | Į. | | USA | | |
| | death item: | | 11. Marital Status 12. Was Decedent Ever in t Armed Forces? | | Was Decedent of H | lispanic Origin? (Spean, Mexican, Puerto | ecify Yes or No- | | - America | |
| 36 | after (", or camir | l by | 1 Never Married 2 Married 1 Yes 2 No | | Yes 2 No | | riioari, Gto.) | | k, White, et | |
| 8 | atura cal Ex | Completed by | 3 Widowed 4 Divorced Year or Dates. | | dent's Usual Occup | | | | AATTTC | |
| 15 | an "n Medi | mpl | (Specify only highest grade completed) | (Give I | kind of work done of NOT use retired) | during most of work | ing | 16b. Kind of Bu | siness/Indi | ustry |
| 212 | withir giene er th | | Elementary/Secondary (0-12) College (1-4 or 5+) | | eteria Wo | | | Public | Scho | ols |
| nd | Id be filed within 72 hours after death with the Manyland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho artic event, the Medical Examiner must be notified at | o Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | | | | |
| Maryland 21215-0036 | Ment Marke Parke | P. | Charles Welburn Gentry | | | Minnie | Virgini | la Wilco | ζ | |
| Mar | should h and Me 7 is marl traumati | | 19a. Informant's Name/Relationship (Type, Print) | 1.0 | | and Number or Rura | | | | · |
| ď | 1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | Karen Compton / Daughter 20a. Method of Disposition | Place of Dispo | | Road, W | 7 | | | |
| nor | age 1 ant of it: If it | | 1X Burial 2 ☐ Cremation 3 ☐ Removal from State | cemetery, cren | natory or other plac | ce) | Date | 20c. Location - 0 | - | |
| Baltimore, | permit. Page 1 a Department of h Important: If ite any injury or ot | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses | | | Gdn: 7/14 ss of Facility Ma | | Bel Air | | - |
| B | Dep Imp any onc | Į, į | Steller al Much | | | adway, Be. | | | | |
| u | | | 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. | | | | | | | Approximate |
| 4 | nysician/ | il i | Immediate Cause (Final disease or condition | ممم | | | | | | Interval Between Onset and Death |
| | Medical Examiner | | resulting in death) a. Due to (or as a conse | quence of): | | | | | - 1 | 1995 |
| | Lxdiffiller | - O | Sequentially list conditions, b. | 0_ | | | | | 1 | -2 weeks |
| | ed nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 4 7 | | | | | | |
| | xecut and al-trai | Exa | that initiated events resulting in death) Last C. Due to (or as a conse | quence of): | 1in | | | | + ' | weeks |
| 00 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit. | dical | d. GERO | _ | | | | | | years |
| 9/8 | ifficate ng phy as th | Med | IF FEMALE: | | - 2: | | | | | |
| × 68 | h cert tendir vr use | an/ | 23b. Was decedent pregnant in the past 12 months? | | Ectopic pregnanc | EV. | | 23d. Date | of deliver | у |
| Rox | deat the at ned fo | Physician/Me | 1 Yes 2 No 4 Pregnant at time o | | Other (specify) | | | Mon | th D | Day Year |
| л Э | at the d by 1 detacl | | Part II. Other significant conditions contributing to death but not re | esulting in the u | nderlying cause giv | en in Part I. | 23e Did to | bacco use contrib | oute to the | cause of death? |
| ις. Τ | res th signe d be (| d b | CAF hypatho | _ | | | | | | ably 4 Unknown |
| ord | been shoul | lete | Dm | , | | | 24a. Was a | | | sy findings available |
| Kecords, | ne law e has age 2 | Completed by | Renal Failure | | | | autop | sy pr med? de | ior to com eath? | pletion of cause of |
| <u>e</u> | an: TI tificat tor, p | | 25. Was case referred to medical | | 26. Pl | ace of Death (Check | 1 Yes | 2 No 1 | ☐ Yes 2 | ! ∐ No |
| Vital | nysici nis cer direc | To B | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 | ☐ ER/Outpatien | t 3 DOA Othe | er: 4 Nursing Ho | me 5 🗶 Resid | ence 6 🗆 Other | (Specify) | |
| 0 | ng Pł fter th uneral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) | 28b. Time of injury | 28c. Injury work | / at | | ow injury occurred | | |
| 0 | tendi Jeath. Ior: A the fu | ifice | 2 Accident Investigation | | M 1 🗆 | Yes 2 □ No | | _ | | |
| DIVISION OF | To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2 s | Certificate: | 4 Homicide determined 28e. Place of Injury - At I building, etc. (Speci | | eet, factory, office | | 28f. Location (S City or Tow | treet and Number n, State) | or Rural F | Route Number, |
| ב | spital nours neral l | | 29a. Certifier 1 Certifying Physician: To the best of my kno | wledge, death o | occurred at the time | e, date and place, a | nd due to the ca | use(s) and manne | r as stated | 2 |
| | ne Ho in 24 h ne Fui pletely | Medical | (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of | on and/or invest | igation, in my opinic | on, death occurred at | the time, date ar | nd place, and due | to the caus | e(s) and manner stated. |
| | Vith To the come | | 29b. Signature and title of certifier | | 29c. License | | | 29d. Date signed | | ay, Year) |
| | | | 30. Name and address of person who completed cause of death (Ite | | D3 | 1295 | | 7/11/12 | | |
|) | | | 30. Name and address of person who completed cause of death (Ite | m 23a) (Type, P | rint) | 1. 1 | | 100 | المسيدة | , |
| | Stat | e | 30. Name and address of person who completed cause of death (Ite Wends Klots 1 2015) 31. Date filed (Month, Day, Year) JUL 13 2012 Less 2 | ature | wer- 17th | _ 11011 | 1-14 C.J.E. | 10.13 | 1201 | -3 |
| | Registra | • | JUL 1 3 2012 Senter 1 | . par | le | | | | | |
| DHM | | | | * | | | | | | - |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G929 Department of Health and Mental Hygiene 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 8,2012 4:30 A.M MARGARET E. LANCELLOTTI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4309 HALLFIELD MANOR DRIVE **NOTTINGHAM** BALTIMORE Social Security Number 6. Sex . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours Months Days 215-84-1733 Director 1 □ M 2 🛣 F 51 2-15-1961 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTO. PERRY HALL 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 9118 SNYDER LANE 21128 **IISA** death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces 1 Never Married 2 X Married Black White etc þ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Tes 2 No WHITE "natural", 3 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the ACCOUNTANT ACCOUNTING SERVICES 12TH traumatic event. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ၉ PAUL J. SCHULTZ MARY L. KAISER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health RALPH L. LANCELLOTTI, JR. SPOUSE 9118 SNYDER LANE PERRY HALL, MD. 21128 20a. Method of Disposition
1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 0 Department Important: If any injury or once. 4 Donation 5 Other (Specify) PARKWOOD 7-12-2012 PARKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on ea Interval Between
Onset and Death
3 42 cm H Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as the attending IF FEMALE for use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day ed by the a detached t P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be Division of Vital Records. Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No MOTHER-IN-LAW s ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 27. Manner of Death Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funer Certificate: 28d. Bescribe how injury occurred 1 Anatural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Mouse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of certifi 29d. Date signed (Month, Day, Year) 2 0/2 30. Name and address of persor death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 28e f per me 9929 7-26-12 vt
State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 540 bnathan Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland Baltimore City 24 Hrs Min. Date of Birth (Nonth, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 216-43-093 1 🛛 M 2 🗆 F 12/27/1994 MD **Director** Yrs 17 or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director other traumatic event, the Medical Examiner must be notified Street 1 Yes 2 X No Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 23a 21154 3131 Copenhaver Road d Mental Hygiene. marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) High School Student 11th Be 18. Mother's Name (First, Middle, Maiden Surname) be filed 17. Father's Name (First, Middle, Last) th and Mental I Joyce Lynne Spitzer Leroy J. Levee, IV and 2 should b Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3131 Copenhaver Rd., Street, MD Leroy J. Levee, IV - Father Department of Healt Important; If Item 2 any injury or other once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Page 1 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 107/07/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner EXAMIN Sequer tially list ounditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a conse resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months? Pregnant at time of death Unknown 2 No a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perforn death? 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Be 25 Was case referred to medica filled in by the funeral director, 1 Yes Other: 2 🗌 No Marient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 27. Manner of Death Certificate: 1 Accident 5 Pending 1200 AM s after death. Fe pranut 25 2014 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home Suicide 28f. Lo tion (Street and Number or Rural Route Number, 4 Homicide determined 3131 Coppenhaver City or Town, State) Street, Mdwithin 24 hours a

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar Grazne egistrar's Signatu Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2012 Physician/ 9 7:19 A^{M} Jane Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 465-94-8842 1 □ M 2 🖔 F Director September 20,1944 China Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò "natural", or items 23a 16604 Bethayres Road 20855 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: Asian 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Computer Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chen-Shao Lo Yun-Hsiao Ying 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16604 Bethayres Road, Rockville, Maryland 20855 Chwan-Kang Chiang / Husband Baltimore, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of July 17, 2012 cemetery, crematory or other place) Rockville, Maryland Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Magelette Banno M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pailure espiratom Physician/ disease or condition resulting in death) Medical Due to (or **Examiner** Sequentially list conditions Examine Due to or as a consequence of it any, saying to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy filled in by the funeral director, page 2 performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 1 ☐ Yes 2 🔀 No မှ 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury 2 Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier July 9, 2012 D0064502 and address of person who completed eduse of death (Item 23a) (Type, Print)

Carpenter, MD 9901 Medical "Center Drive, podunits Carpenter mo Brian 31. Date filed (Month, Day, Year) Registrar's Signature State 1 3 2012

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ McCalla oxanne 0320AM Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL Baltimore INION If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months **Director** 1 M 2 X F MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County Director must be notified 1 Yes 2 ☐ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 Funeral items 23a 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Black, White, etc. ò 1X Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 nours after 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry PUBLIC SCHOOL Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4100 the SYSTEM other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MCCALLA TAMES BRAWNER THELMA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Legartment of Health ar Important; If item 27 is ny injury or other trau once. HARRIS (OTR) SCHAUB AVE. BALTO, MD. 21206 DéJournae 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
ON-SITE CREM ATTURY ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, Md 20 4 Donation 5 Other (Specify) Vaughn GREENE FUNCEAR SURS Ħ ē Balto, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumana day disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis days Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or injury that initiated events Obstructue Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the at P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 End stage Renal Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No tibrillano 24a. Was an autopsy performed? Yes 2 No has 25. Was case referred to medical 26. Place of Death (Check only one) e B examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of I Director: After the din by the funeral Certificate: 28d. Describe how injury occurred 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 00063163 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RRU Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days (Month, Dav. Year) 15-34-6187 75 Director 1**X**□ M 2 □ F Jan 30, 1937 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖾 No MD Baltimore Baltimore 10g. Citizen of What Country? United States 10e Street and Number 10f. Zip Code 21244 Funeral 1740 Gordon Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: UNK Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Meury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Koppers INC. Machinist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildre Marie Wright Isadore Carr Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9930 Old Court Rd. Woodstock, MD 21163 Nelson Mathews (Brother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If its
any injury or of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/14/2012 Woodstock, MD 4 ☐ Donation 5 ☐ Other (Specify) Granite Cemetery Signature of Funeral Service ²² Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ō: Completed by 2 No 3 □ Probably 4 □ Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerform 2 🗌 No 1 ☐ Yes 2 ☐ 1 🗌 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Sp.)} \) Hospital 2 100 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 D Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and afte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene TRT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 120 VULLY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BAKTIMORE 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth Months Hours Min. (Month, Day, Year) Director 1 ★M 2 🗆 F 1938 NORTH or 28a-f shov 10b. County City, Town or Location Examiner must be notified at 10c **Funeral Director** 10d. Inside City Limits DALTIMORE 1 XYes 2 No land Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a death with 2/229 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Was Decedent Even III C.S. Armed Forces?

1 A Yes 2 No If Yes, Give 7-19-55
Year or Dates. 7.24-57 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced AMERICAN event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) ORKers marked other Be Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 1ERCER Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 461 neresa And OKE 1000 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 16,2012 21. Signature of Funeral Service Licensee Street-Baltimore Md. 21229 W Franklin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Runal Onset and Death Physician/ THILUPS MULTIORGAN disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MALIGNAN GASTRIC とそろうひろん JASTPOINTESTINA Sequentially list conditions, il any, leading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for Pregnant at time of death Other (specify) Month Day Year 4 Pregnant : 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed After this certificate 2 1 No 2 1 Tes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28b. 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: completely filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70718 MD JULY 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORY 900 SOUTH MARULANI) CEDRIC DARK AVENUE 21229 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 3 201 Registrar

/DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Flora Bell Month Year Murphy 22 58 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 212-28-5164 Country) **Director** 1 M 2 XF 84 Yrs 2/24/1928 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director MD N/A Baltimore-1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe Funeral or than "natural", or items 23a the Medical Examiner must by 5212 The Alameda 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗶 No If Yes, Give Murphy - 1000 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ; 1 and 2 should be filed within 7 of Health and Mental Hygiene. filtem 27 is marked other than rother traumatic event, the Ms. Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elijah Taylor Hester Mae Crane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Blackwell-Daughter 1350 Halstead Rd. Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arbutus Mem. Pk. 7/14/2012 ÷ 5 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Halethorpe, MD 4 ☐ Donation 5 ☐ Other (Specify) March F/H- East 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ arrhythmi Medical resulting in death) Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (r as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months' Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Chronic renal insulficience 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No Yes 2 L To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 19 No ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To time best of my knowledge sheath occurred at the time date and place, and due to the cause(s) and manner at attention. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuthlian LAtra DOOK 2689 July 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Good Samaritan Hospital Balto, Md WN

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | 4 | State of Maryland / Department of Health and Mental Hygiene Cortificate of Death Cortificate of Death | | | | | | | |
|-------------------|--|---|--|--|--|----------------------------|------------------------------------|-----------------------|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | egistrar Certificate of Death Reg. No. | | | | | | |
| | Physicia Medic | n/ al | Sheila | Mc Clean July By 201 | | | | | | |
| | Examin | er | 4a. Eacility Name (if not institution, give street and quell here.) The Johns Hopk | ins Hospita | al Balt | more of Death | - City | 4c. County of Death | | |
| | Funeral Director | | 5. Social Security Number 213-52-5131 6. Sex | 7. Age (In yrs. last birthda) | Months Days I | Hours Min. | Date of Birth (Month, Day, Year | r) Cour | ** | |
| | | _ | Usual Residence of Decedent 10a. State 10b. County | 67 Yrs. | | 1 10 | 08/16/19 | | yland 10d. Inside City Limits | |
| | //arylan 8a-f sh tified a | Director | MD N/A | 1.001.01(), 1.011.1 | Baltir | more | | | 1X☐ Yes 2☐ No | |
| | th the l | al Di | 10e. Street and Number | | 10f. Zip Code | 0.7 | 10g. | Citizen of What Cou | ntry? | |
| | ath wi | Funeral | 2914 Oakhill Ave. | edent Ever in U.S. | 2120 3. Was Decedent of Hispa If Yes, specify Cuban, I | | / Yes or No- | U.S.A. | can Indian, | |
| 36 | ifter de | by | 1 Never Married 2 Married Armed F | 2 🗔 No | If Yes, specify Cuban, I | | an, etc.) | Black, White, | etc. lack | |
| 00- | hours a natural iical Ex | letec | 3 ☐ Widowed 4 ☑ Divorced Year or I | 16a. De | cedent's Usual Occupation | on , , , , , , , , , , , , | 16b | . Kind of Business/Ir | | |
| 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed | (Specify only highest grade complete Flementary/Secondary (0-12) College Tin Grade | 1-4 or 5+) life. | ve kind of work done duri . DO NOT use retired) aborer | ing most of working | | Chimes | | |
| | should be filed within and Mental Hygiene. is marked other tha aumatic event, the n | Be | 17. Father's Name (First, Middle, Last) | | | 8. Mother's Name (F | irst, Middle, Maide | en Surname) | | |
| Maryland | uid be d Ment marked natic e | 2 | Joseph Brown Sr. 19a. Informant's Name/Relationship (Type, Print) | | ailing Address (Street and | Juanita | | | Cadal | |
| | d 2 sho alth and 1 27 is i | l | Joseph W. Brown Jr | | | | | | | |
| ore, | ge 1 and to the troit He in the troit is the troit in the | | 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal fro | 20b. Place of Dis | sposition (Name of crematory or other place) e Creamtoi | Date CALL | · I | Location - City or T | | |
| Baltimore, | permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra | | 4 Donation 5 Other (Specify) 21. Si vature of Funeral Servi | | | | | | | |
| ä | Depar Impo any ir | | Macqueline / | | joseph ^{Ad} H ^{ess} i 2140 N. Fi | | | timore, | | |
| | | | 23a. Pan 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final | ealth line. | enter the mode of dying, s mbolic | | espiratory arrest, | | Approximate Interval Between Onset and Death | |
| | Medical Examiner | | diffase or condition resulting in death) a. Due to | o (or as a consequence of): | -11100110 | | | | | |
| t. | Examiner | ler. | Sequentially list conditions, if any, leading to immediate b. | o (or as a consequence of): | | | | | | |
| | ecuted and II-transit | camir | Cause. Enter Underlying Cause (Disease or injury that initiated events C. | | | | | | | |
| | oe executed iician and burial-transit | calE | resulting in death) Last Due t | o (or as a consequence of): | | | | | | |
| 68760 | ficate l g phys as the | Media | IF FEMALE: | | | | | | | |
| Box 68 | ath cert attendin for use | ian/I | 23b. Was decedent pregnant in the past 12 months? | utcome of pregnancy e Birth 2 Fetal death egnant at time of death | 3 Ectopic pregnancy 5 Other (specify) | | | 23d. Date of deli | very Day Year | |
| | the dea by the a | hysic | g Unknown g Ur | known | | | 1 | | | |
| s, P.O. | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi | Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to | death but not resulting in the | ne underlying cause given | n in Part I. | 23e. Did tobacc | 2 No 3 Pro | the cause of death? | |
| Records, | w requi s been 2 shoul | plete | | · · | | | 24a. Was an autopsy | 24b. Were auto | opsy findings available ompletion of cause of | |
| Rec | sician: The law r certificate has b lirector, page 2 s | Com | | | | | performed | ? death? | 2 No | |
| /ital | sician certifi lirector | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | Ampatient 2 ☐ ER/Outpa | Other: | e of Death (Check or | | 6 Other (Special | 6v) | |
| Division of Vital | this | ate: To | 27. Manner of Death 28a. Da | e of injury 28b. Time onth, Day, Year) 28b. Time | e of 28c. Injury a work? | t 286 | d. Describe how in | | <i>X</i> / | |
| sion | Attendir death. | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be | ce of Injury - At home, farm, | | es 2 🗆 No 28 | | and Number or Rura | al Route Number, | |
| Ď. | ital or alteral Directory | | Dul | ding, etc. (Specify) | | | City or Town, St | | | |
| | To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | To the within To the comp | _ | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | |
| | HJ | | 30. Name(and addless of person who complated ca | use of death (Item 23a) (Typ | pe, Print) (1) | rlean | s S+ | Baltin | nore MD | |
| | Sta | | 31. Date filed (Month, Day, Year) 32 | Aegistrar's Signature | 7 | 1 10001 | | .50 | | |
| | Registr | ar | JUL 1 3 2012 Z | neva B. A | Barker | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 21972 6:45 AM Lucille Kemp Nelson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death AGNES HESPITTLL BALTIMORES 5. Social Security Number If Unde If Under 24 Hrs. 6. Sex 7. Age (In yrs. 80 Year 8. Date of Birth 9. Birthplace (State or Foreign last birthday **Funeral** 1 □ M 2 🛣 June 26 ^{Year)} 19<u>32</u> Maine Months 004-28-0297 **Director** Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Marvland Baltimore Catonsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 713 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 XWidowed 4 Divorced Medical 15. Decedent's Education 16b. Kind of Business Industry
Prince George's County 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Valley Kemp Beatrice Bragdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Nelson/son 2091 Pear Hill Court Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Trinity Cemetery 06/12/2012 | Bowie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MacNabb Funeral Home, P.A. Stephanie Custer 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Oncet and Death Immediate Cause (Final SHADHRAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NECHANICAL FALL Sequentially list conditions, Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2 □ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural
2 Accident 28c. Injury at 28d. Describe how injury occurred FALL HIPO AM 5 Pending KINC 2 20/2 1 Tyes Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13 Marien Chille Carl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined name Cotaminity; MD To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 do 30. Name and address of person who completed cause of death (Item

JPW W-8 NOS W. 1 S W.179 BALTIMERE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day 1111 1 3 2012

WELSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10° 2012 Castle Newell July Ruth 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9204 Farnsworth Drive Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 290-42-6518 1 □ M 2 🛣 F 93 Yrs December 6, 1918 Ohio Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20854 9204 Farnsworth Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other threamy injury or other traumatic event, the 1 once. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morrison Henry Castle Jennie Bell Sinclair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Molly N. Singerling /Daughter 6108 Woodmont Road, Alexandria, Virginia 22307 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gates Mills South July 17, 2012 Gates Mills, Ohio 4 ☐ Donation 5 ☐ Other (Specify) <u>Cemetery</u> 21. Signature of Financial Sepoice Licensee Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 mysette Brown M01305 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Urosepsis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dehydration, Fever 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 🗍 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? has 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 💢 No Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 🗌 No Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral I

29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) DC16518 July 11, 2012 30. Name and address of person who completed ca e of death (Item 23a) (Type, Print) Joel Guiterman, MD 2141 K Street, NW, Suite 603, Washington, D.C. 20037 31. Date filed (Month, Day, Year) State 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Innette 2:15PM 2012 07 Medical 4b. City, Town, or Location.
Silver Spring 4a. Facility Name (if not institution, give street and **Examiner** 4c. County of Death Home ! Prehab Chase Nursing Montgomen last birthday, 7. Age (In 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** 214.24.315 1 M 2 X (Month, Day, Yea ntry) SC Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Locust Road 20012 USA Page 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 No Specify Specify: Black 3

Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care LPN 6th grade Be Maryland 17. Father's Name (First, Middle, Last) WIN 18. Mother's Name (First, Middle, Maiden Surname) ျှ Grace Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand 2744 Sweet Clover Court Silver Spring MD 20904 Carde Dean Daughter timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Number 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD Arbutu Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility \ augus C. Greene Funoral serves Koad Kandallstonn MD 2113 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he ure. List only one cause on each line Interval Between Onset and Death Immediate Cause Niga Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Vo
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? monora 2 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the heartal or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy perform death? 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1-Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 05226 10 30. Name and address of person who completed cause of death (Item 23a) (Type Hugo pring JIR. 31. Date filed (Month, Day, Year)

JUL 1 3 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, pt.II.25 per me. 929 7-31-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 AM 2012 aulin resa Medical Facility Name (if not institution, give street and num County of Death 4b. City, Tox **Examiner** Burnie Glen thine Nashina ledica Mmore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 228.02.3514 1 🗆 M 2 🕮 Yrs. 53 MARCH 22, 1959 MD 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 270 CROSS CREEK DR. 21061 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 XX Married by 1 Yes 2xx No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 **BANKING** FINANCIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARIE ANN JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270 CROSS CREEK DR. GLEN BURNIE, MD 21061 **DWIGHT PAULIN** HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place BAYVIEW CREMATORY INC 7.10.2012 4 Donation 5 Other (Specify) BALTIMORE, MD rare of Funeral Se vide Vicense 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW CLEN BURNIE, MD 21061 K. CRECORY FINK MO1148 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. 23a. Part 1 Approximate interval Retween nset and Death Immediate Cause (Final Physician/ embolic Cerebra disease or condition resulting in death) Medical **Examiner** endocar Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EX as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 100 To the Hospital or Attending Physician: The law autopsy 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, ER/Outpatient After this Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 6824 pleted cause of death (Iten 30 705

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZO1 132 Medical (if not institution, give street and number) or Location of Death **Examiner** 4c. MOVE 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Min. **Director** 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No nne 10e. Street and Numbe 0 ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral death 12. Was Decement Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian Black, White, etc. þ Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 2 No Specify: 1 Yes "natural", Completed 3 🗌 Widowed 4 🗎 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) ည Name/Relationshim 19b. Mailing Address (Street and Numbe Town, State, 20a. Method Disposition 20b. Place of Disposition (Name of i o i 1 Burial 2 Cremation
4 Dopation 5 Other is cemetery, crematory or other place 3 Removal from State Department of Important: If any injury or Signature of 5 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury for use as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month been signed by the sahould be detached 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, Completed 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in but has furnary and an analysis. page 2 s autopsy 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$ BHAL MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 12, Day 2012 Year James D. Phillips 3:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manor Care Ruxton Baltimore Towson . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** Month, Day, Year)

13,1930 Hours 1 M 2 X F Months **Director** 213-24-7021 82 June Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore Parkville 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3214 Texas Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc δ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene, smarked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Chesapeake Finished Metal Coating 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental F tant: If item 27 is marked o မ Aubrey H. Phillips Theressa M. Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3214 Texas Avenue-Parkville, Maryland 21234 Eleanor Phillips-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Department Important: I July 16,2012 Parkville, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ arrhythmin disease or condition resulting in death) ardiac min Medical Due to (or as a consequence of **Examiner** disease, obstructive by monery Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury bronchitis Chronic that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ma) nutrition Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of Chronia anemia 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page phlmonale 2 🔀 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director, After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7-12-2012 D-14957 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Baltimore -HIMIL 8769 Rd. Hartord MD Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2012 ALBERT ELLIOTT PRICE Physician/ 1111 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) BALTIMORE Examiner TOWSON GILCHRIST CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Year) b. 11, 1920 **Funeral** MD. eb 213-05-6946 XXM 2 F 92 Director Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location ar then "naturel", or items 23a or 28e-f show the Medical Examiner must be neithed at 10b. County Director 1 Yes 2 (No Towson Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 1000 East Joppa Rd. Apt. 207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Specify: Š 1 ☐ Yes XX No Specify: Page 1 end 2 should be filed within 72 hours efter White Baltimore, Maryland 21215-0036 3 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Prudential Life Ins. of the state of th College (1-4 or 5+) Flementary/Secondary (0-12) Company Insurance Agent 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Sarah Collison Albert Elliott Price, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 207 Baltimore, Md. 21286 Depertment of Heelth ar Important: If item 27 is eny injury or other treu once. 1000 East Joppa Apt. Joyce C. Price (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore , 7-14-2012 Glen Haven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home, 7401 Belair Rd. Baltimore, Md. 21236 21 Signature of Funeral Service Licensee 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SUBOURSU Immediate Cause (Final disease or condition resulting in death) .Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine ted by the attending physician and detached for use es the burial-transit Cause (Disease or injury The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23d. Date of delivery IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 3 Ectopic pregnance 5 Other (specify) Year Month Day in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying 🤝 se given in P 3 Probably 4 Unknown by 2 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes 26. Place of Death (Check only one) To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical **Division of Vital** Be 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hospice Other: examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 🗆 No 1 Yes ျ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: Zoo work? 1 ☐ Yes 2 ☑ No tound on Floor 1 Natural 5 Pending 2012 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suicide JOPPARD, TOUSON MD 4 Homicide 1000 Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 State

31. Date filed (Month, Day, Year)

501

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Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month М 2012 Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min Director 1 X M 2 🗆 F -10-1967 sidence of Decedent 28a-f show 10c. City, Town or Location with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. Count 10d. Inside City Limits Director 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō þ 🗌 Yes 2 🗙 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NQT use retired) and Mental Hygiene.

is marked other than within 7 Elementary/Secondary (0-12) College (1-4 or 5+) []th abover Various Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evo မ Powell Jordan 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2504 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of). executed the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe death? 2 No Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be hours after deat neral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

. Date filed (Month, Day, Year)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ JoAnn Pfeiffer : 36 PM 20/2 1464 Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL 57 BALTIMORE AGNES Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 219-26-9996 **Director** 1 ☐ M 2**X**XF 74 West Virginia 01-30-1938 Usual Residence of Decede 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2XXNo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 United States 4214 Kensington Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transpines ည Virginia Miller Kenneth Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8803 Pikesville Road, Pikesville, MD 21208 Jennifer L. Dillon - daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 07-03-2012 Glen Burnie, MD Atlantic Crematory 4 Donat on 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 MMP. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Panceali i Onset and Death

2 Week CANCEL Phylician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 willih no navy if any, leading to immediate cause. Enter Underlying Examine 2 mell neumon/4 Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence attending physician I for use as the buria Myocaldia Physician/Medical death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached f or Attending Physician: The law requires that the P.0. 224 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed? Yes 2 2 100 Yes Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA ithin 24 hours after occur.

o the Funeral Director: After th 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MP. 25490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) more (21221, MD S MAR CATON Ave 900 31. Date filed (Month Year) State

DHMH 17 Rev 06-2011

Registrar

JUL 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 11 2012 3:21 A^{M} Nicholas Miltiades Papadopoulos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 579-48-4690 **Director** 1 **X** M 2 □ F Yrs. July 21, 1923 Greece 88 Usual Residence of Decede 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20814 7401 Westlake Terrace, #609 United States tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 K Married "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Biochemist other traumatic event, Be should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H Miltiades Papadopoulos Vasiliki Zois 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 12577 Ansin Circle Drive, Potomac, Maryland 20854 Thomas N. Papadopoulos / Son 20a, Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date ~13, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 9 Department or Important: If any injury or once. Silver Spring, Maryland Gate of Heaven Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20850-2805 Signature of Funeral Service Licenses · Cargefette Browns M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of Exami executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 7/11/2011 IF FEMALE use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal deat
 Pregnant at time of death
 Unknown page 2 should be detached for in the past 12 months? Day Month Year 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate has To the Hospital or Attending Physician: filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆

State Registrar

Papadopoulos,

icholas

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

Latoya Miller, MD 31. Date filed (Month, Day, Year)

1 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Backe

D0067722

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

July 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 Month 0 Physician/ Day 012 Year 6:05 p Juanita Ramsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Univ. of Maryland Medical Ctr 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Hours 12-06-1953 218-62-4068 **Director** 58 SC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code ö ms 23a or must be r 10g. Citizen of What Country? by Funeral 21213 USA 2305 Federal Street Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Specify. Completed Year or Dates **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of MD District Court Clerk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruby Crawford Albert White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21215 William Ramsey/Husband 2932 Oakford Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislasus Cem.: 7-17-2012 | Baltimore, MD 22. Name and Address of Facility James~A.~Morton~&~Sons~F.H., Inc.Si mature of Funeral Service Licensee 1701-31 Laurens St. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Leukemia Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Oncerning Cause (Disease or iinjury Due to (or as a consequence of): Exami Liver Failure or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialphysician Pulmonary failure Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 9 Unknown this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia, asthma, c-difficile, atrial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown fibrillation, percardial effusion, DVT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes : After this certification : 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 1 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Authority within 24 hours after death.

To the Funeral Director: After Ammeleted filled in by the fur 1 X Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, July 12, 2012 29c. License number July P27405

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Carina A. Sorenson 22 S. Greene St., Baltimore, Md 21201

| 12- | 051 | 150 |
|-----|-----|-----|
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Please Type or Print in Rlack Indelible Ink Figure All Copies Are Legible

| ernard R. Ryna | rzev | wski State of Maryland / Dep | artment of Health and Mental H | |
|---|----------------|--|---|---|
| oma on ryma | | 1- For State | ertificate of Death | Reg. No. |
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | 0 | 2. Date of Death 3. Time of Death |
| Medical Exami | | Bernard Ronald | Kynarzewski | July 9, 2012 |
| | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death Baltimore | 4c. County of Death |
| | | Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. | | s. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or |
| Funeral Director | | 0 1/2 | Months Days Hours Min | Foreign |
| | k | Usual Residence of Decedent | O Yrs. | 06-12-1952 Country) MD |
| any | ŀ | | y, Town or Location | 10d, Inside City Limits |
| nd ihow | _ |) GM | Saltimore | 1 Syles 2 No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| death with the Maryland or items 23a or 28a-f sho must he notified at once. | | 3120 Orlando Avenue | 21234 | U.S.A. |
| h with | Funeral | 11. Marital Status 12. Was Decedent Ever in Armed Forces? | U.S. 13. Was Decedent of Hispanic Origin? (S | |
| r deat | 튑 | 1 Yes 2 No | Ven 2Nd No appoints | Specify: 1 12 + 2 |
| rs afte | 2 | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) | 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of | - WILL |
| 136 thin 72 hours a te. than "natura edical Exami | <u>\$</u> | Elementary/Secondary (0-12) College (1-4 or 5+) | during most of working life, DO NOT use ret | |
| D36 thin 7 ne. | Completed | 4 | Surveyor | Health tacility |
| 5-00 lled wit Hygien I other the M | | 17. Father's Name (First, Middle, Last) | | e (First, Middle, Maiden Surname) |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | Be | Bernard Joseph | Rynarzewskil Emil | Rural Route Number, City or Town, Sate, Zip ode) |
| → 2 2 3 2 1 | ٩ | 19a. Informant's Name/Relationship (Type, Print) Obin Thomason/Daudter | The Mailing Address (Street and Number of | Political No. 1286 |
| ore, MC es 1 and 2 sl of Health ar If item 27 | - 1 | | Place of Disposition (Name of cemetery, | Date 20c. Location - City or Town, State |
| Baltimore, permit. Pages I as Department of He Important: If ite | - 1 | 1 Burial 2 Cremation 3 Removal from State | crematory or other place) | 1.12 2017 Roltsville MD |
| | ł | 4 Donation 5 Other Specify: Signature of Funeral Service Licensee Output MO144 | 22. Name and Address of Facility | Cheshen D. Common, PA |
| Balti permit. Departu Importi | - | La de dua Ritter | 18717 Green Yast | arcs Dr. Batto. MD 21286 |
| Physician | | 23a. Rart I. Enter the disease, or complications that caused the dea failure. List only one cause on each line. Atherosc1 | th. Do not enter the mode of dying, such as cardiac erotic Cardiovascular D | or respiratory arrest, shock, or heart / Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease a. complicated b | y Cocaine Usage | Death |
| and the second | - | or condition resulting in death) Due to (or as a consequence | of): | |
| | ě | Sequentially list conditions, if any, leading to immediate Duc to (or as a consequence | of): | |
| | ä | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence | of): | |
| rand - transit | ical Examiner | d d | | |
| क है व | | ✓ UNPENDED ☐ AMENDED 23a,27, | per me,g929 7-27-12 sm | |
| ox 68760, ath certificate be attending physic or use as the buri | /Me | IF FEMALE: 23b. Was decedent pregnant in the | □ - · · · · · · · · · · · · · · · · · · | 23d. Date of delivery ancy Month Day Year |
| x 68 h certifi ending use as | ian | 23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of | 2 Fetal death 3 Ectopic pregn | ancy Month Day Year |
| Box 68760, s death certificate be the attending physic ed for use as the bur | Physician/Med | 1 Yes 2 No 9 Unknown | | |
| P.O. B that the de ned by the detached i | | Part II. Other significant conditions contributing to death but no | t resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown |
| S, P.C uires that n signed l | Completed by | | | 24a. Was an 24b. Were autopsy findings available |
| ord Iw req as bee | plet | | | autopsy prior to completion of cause of death? |
| Rec The Is | ĕ | | | 1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | Be (| 25. Was case referred to medical examiner? Hospital: A leasting 2. | 26.Place of Death (Check ER/Outpatient 3 DOA Other4 Nursi | ng Home 5 Residence 6 Other: |
| f Vic | ဥ | 1 Yes 2 No Inpatient 2 2 2 27. Manner of Death 28a. Date of Injury | ER/Outpatient 3 DOA Other Mursi 28b. Time of Injury 28c. Injury at Work? | 28d, Describe how injury occurred |
| on of ading Pl th. | Certification: | 1 X Natural 5 Pending (Month, Day, Year) | 1 Yes 2 No | |
| isic r Atte er dea rector | ficat | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At | home, farm, street, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, City |
| Div | erti | Suicide 6 Could not be determined (Specify) | | or Town, State) |
| Hosp 24 ho Fune | | (6,105,105,105,105,105,105,105,105,105,105 | edge, death occurred at the time, date and place, an | d due to the cause(s) and manner as stated. |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn | Medical | and manner stated. | | at the time, date and place, and due to the cause(s) |
| | Σ | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | 29d. Date signed (Month, Day, Year) July 10, 2012 |
| (3),8 | | (Criment | <u></u> _ | July 10, 2012 |
| 9x40 | | 30 Name and address of person who completed cause of death (Ite Laron Locke MD. Assistant Medical Examine | em 23a) r = 900 W. Baltimore Street, Baltimore, | MD 21223 |
| S | tate | Ot B to St. Late t | | |
| Pogie | | 1111 1 2 2012 | | |

DHMH 17 Rev 1/2001 OCME 2006

OCME THEO

12-05194 Patricia Ruth Ray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Patricia Ruth Ray State of Maryland / Department of Health and Mental Hygiene 2012 221 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 10, 2012 1158 hrs Kuth **Medical Examiner** tatricia 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b, City, Town, or Location of Death 3602 Lyndale Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Country) D.C. Director 213-58-0758 1 M 2 XF Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Baltimore 1 Yes 2 No 28a-f shn tem 27 is marked other than "natural", or items 23a nr 28a-f shn traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3602 Lyndale USA 21213 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 2. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Yes Black timore, MD 21215-0036

• Pages I and 2 should be filed within 72 hours after timent of Health and Mental Hygiene.

tant: Utiem 27 is marked other than "natural", or 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: á 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted Elementary/Secondary (0-12) College (1-4 or 5+) VERIZON 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ALONZO Lyndale Ave, Bulton MO.21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MT Zion Cemeten Donation 5 Other Specify: of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ğ 1 Yes 2 No 3 Probably 4 Vunknown Completed ficate has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed this certificate Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) July 11, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Parkers) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Russell 2012 12:12 P M Barbara Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Co. Annapolis _3/8<u>y</u> N If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min **Director** 1 🗆 M 2 🗓 F 79 Yrs. 11/16/1932 North Carolina 28a-f show at 10a. State 10c. City, Town or Location 10d Inside City Limits Director notified MD 1 🗆 Yes 2 🔀 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? "natural", or items 23a o Funeral with 21060 136 Louise Terrace United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced White Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the A <u>once.</u> Pharmacy Technician 12 yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louise Hogue Jack Lanius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lot 145, Severn, MD 21144 Ms. Sharon Russell / Daughter 7959 Telegraph Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ${f X}$ Burial 2 ${f \Box}$ Cremation 3 ${f \Box}$ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Haven Mem. Park 7/14/2012 Glen Burnie, Maryland Signature of Funday Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 5chemic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Existic (ceas wind recession of cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Direct Cert. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending work? M 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number tto oroye 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) д Medical 31. Date filed (Month Day State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 3:47 Medical atricia Rankh 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number Acil 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Director 218-48-3806 1 □ M 2 🗹 F 9-19-1948 MD Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Pikesville 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4113 Bedford Road 21207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 😾 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Foreign Claim Associate Social Security Admin e 1 and 2 should be filed wit of Health and Mental Hygle of item 27 is marked other ir other traumatic event, the 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic. Joseph T. Walker Rachel Yelliwe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivan Rankhalawan/Husband 4113 Bedford Road, Pikesville, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 7-14-2012 Woodlawn, MD 21. Signature of Junera Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician. disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events treatucucc Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? r this certificate has beral director, page 2 sl 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 2 Accident 5 Pending n 24 hours after death.

The Funeral Director: Af olderely filled in by the funeral filled in by Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 2012 9085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2(133 12 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUL Physician/ $20\overset{\text{rear}}{1}2$ BETTY ANN SINGLETON P^M 10 2:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA NATIONAL MILITARY MEDICAL CENTER If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours Min (Month, Day, Year) 944 Georgia 67 Nov. 242-02-1791 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2X No VA Stafford Stafford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 ral", or items 23a or Examiner must be r 126 Pinta Cove 22554 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 2 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: **Black** "natural". 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) giene. er than ' College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 12 filed wingle Hygie Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I ည Johnnie Simpson Mattie L. Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health s tant: If item 27 i 126 Pinta Cove, Stafford, VA Nathaniel Singleton, Jr.-Husband 22554 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Quantico National Department of Important: If any injury or 4 Donation 5 Other (Specify) 7-16-2012 Triangle, Cemetery 22. Name and Address of Facility Metropolitan Funeral Service 21. Signatury of Funeral Service Licensee 5517 Vine Street, Alexandria, VA 22310 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIAC ARREST Medical Due to (or as a consequence of) Examiner MULTIPLE MYELOMA Sequentially list conditions, Durinto for all a nonseguence of: cause. Enter Underlying Cause (Disease or iinjury Examir -transit CORONARY ARTERY DISEASE and that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician Physician/Medical certificate be Box 68760 d as the l attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 XNo the g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? 2 🗆 No this certificate 1 🗌 Yes Yes 2 X No **Division of Vital** • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 XNo ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury XNatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tit 29d. Date signed (Month. Day, Year) 29c. License number 201

DHMH 17 Rev 7/2009

State Registrar BRIAN M.

CUNEO,

BETHESDA,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)WALTER REED

Pegistrar's Signatur

MILITARY

NATIONAL

20889

MD

MEDICAL CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| enneth Smith | | State of Maryla | | rtment of l | | d Mental | Hygiene | Reg. No. | 20 | 12 2219 |
|--|--------------|---|---|---|---|--|---------------------------------------|---|--|---|
| Physician Medical Examine | 1. | Decedent's Name (First, Middle,Last) Ken Ken | neth Smi | th mith | | | 2. Date of D Month July 9, 2 | eath Day | Year | 3. Time of Death 2048 hrs |
| Page 1 | | a. Facility Name (if not institution, give street and no Johns Hopkins Hospital | umber) | 4b | City, Town, o | Location of De | | | County of Death | 1 |
| Funeral Director | | Social Security Number 214-76-2305 6. Sex | 7. Age (In yrs. la 5.2 | | If Under 1 Year Months Day | | | Birth(MM/D -1960 | Earaid | thplace (State or gn untry) MD |
| w any | <u> </u> | sual Residence of Decedent Da. State 10b. County MD | 10c. City, | Town or Location Balti | | | | | | 10d. Inside City Limits 1 X Yes 2 No |
| th the Maryland 23a nr 28a-f show notified at once. | 1 | De Street and Number 2324 E Oliver Stree | l et | | 10f. Zip Code 212 | 13 | | 10g. Citiz | en of What Cou | ntry? |
| er death wi , or items r must he | 1 | 1. Marital Status 1. Married I 2 Married Armed F 1 X Yes 3 Widowed 4 Divorced If Yes, Give Ye | 2 No | If Yes | s, specify Cuba | | (Specify Yes or erto Rican, etc.) | | 14. Race - Amer White, etc. Specify: B1a | ican Indian, Black, |
| 5-0036 de within 72 hours after than "natural" other than "natural" the Medical Examine Completed by | ?⊢ | 15. Decedent's Education (Specify only highest gra | | 16a. Decedent's during mos | | e. DO NOT use | | 16b. Ki | Housi | · |
| 21215-0036 July be filed within 72 hou Mental Hygene. marked other than "nat c event, the Medical Exa | | 7. Father's Name (First, Middle, Last) Toby Smitl | | | | Jan | ame (First, Middl ie Murc | chisc | n | |
| and 2 should lealth and Meleten 27 is maitraumatic cv | | 9a. Informant's Name/Relationship (Type, Print Da Latarsha Smith | | 2324 | Callo | w Ave | or Rural Route N Apt 3 | Balto | o MD 2 | 1217 |
| Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, | | Oa. Method of Disposition X Burial 2 | from State | Place of Disposit crematory or othe rrison | For (| cem 7 | | 120w | | Mills MD |
| | 1 | 1. Signature of Funeral Service Licensee A A A C L L L L L L L L L L L L L L L L | 100 | 24 | 31 E C | liver | Street | Bal | to MD | ford FS PA 21213 Approximate Interval |
| Physician //Medical Examiner | | failure. List only one cause on each line ${f Ath}$ mmediate Cause (Final disease a. ${f by Hyp}$ | eroscler erthermi | cotic Ca La | rdiovas | cular 1 | Disease | comp1 | icated | Between Onset and Death |
| Same of the same o | | Sequentially list conditions. | a consequence of | | | | | | | |
| ted Insit | Examine | cause. Enter Underlying Cause | a consequence o | | | | | | | |
| execui an and al - tra | | | l per m | | 7-13-12 er me,e | vt 930 8- | 29-12 sm | 234 | . Date of deliver | 7 |
| Box 68760, e death certificate but the attending physic ed for use as the bur | Siciany | Bb. Was decedent pregnant in the past 12 months? | , outcome of preg birth gnant at time of de nown | 2 Feta | al death 3 er (Specify) | Ectopic pr | egnancy | 100 | | Day Year |
| P.O. E es that the es that the egenet by the egenethed | | Part II. Other significant conditions contributing Chronic Alcohol Abuse | to death but not re | esulting in the ur | nderlying cause | given in Part I | 23e. Di | | | the cause of death? |
| Division of Vital Records, P.O. B as are death. 1 and rectain Physician: The law requires that the death that the process of the former and director, page 2 should be detached. | Completed | | | | | | 1 ✓ Y€ | as an utopsy erformed? es 2 No | prior to death? | utopsy findings available completion of cause of |
| ital Bician: | a ' | 5. Was case referred to medical examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient | | Other N | ursing Home 5 | Reside | nce 6 Othe | er: |
| on of V ending Physath. or: After thi | 의 | 1 Netural (Mor | e of Injury hth, Day,Year) | 28b. Time of In | jury 28c. In | jury at Work? | expos | sure 1 | ry occurred | eme |
| S de | | | 7-8-12 | fd20:4 | _ ma_0 | 100 222 | l envi r | onmen | tal tem | peratures |
| Divi | ertification | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specification) 4 Homicide (Specification) | | | Opm | building, etc. | 28f. Location or Tow Balti | onmen on (Street a n, State) 2 more | tal tem nd Number or R 324 East MD | ural Route Number, City t Oliver St. |
| Divi | Certific | 2 Accident 3 Suicide 4 Homicide 29a. Certifylng Physician: To the basis and manner: | ace of Injury - At h y) est of my knowled s of examination a | ome, farm, stree | t, factory, office | building, etc. date and place on, death occur | 28f. Location or Tow Balti | onmen on (Street a n, State) 2 more ause(s) an ate and pla | tal tem nd Number or R 324 East MD d manner as sta ce, and due to t | tral Route Number, City t Oliver St. atted. he cause(s) |
| ie bou | dical | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specification of Check only) 2 Accident Investigation 28e. Plate determined (Specification of Check only) 2 Medical Examiner: On the basing the control of the control | ace of Injury - At h y) est of my knowled s of examination a | ome, farm, stree | t, factory, office red at the time, on, in my opinion | building, etc. | 28f. Location or Tow Balti | onmen on (Street a n, State) 2 more ause(s) an ate and pla | tal tem nd Number or R 324 East MD d manner as sta | trail Route Number, City t Oliver St. atted. he cause(s) |
| Divi | Medical | 2 Accident 3 Suicide 4 Homicide 29a. Certifylng Physician: To the basis and manner: | ace of Injury - At h y) est of my knowled s of examination a stated. | ome, farm, stree lge, death occurr and/or investigati | t, factory, officered at the time, on, in my opinion 29c. Licel | date and place on, death occur unsernumber | 28f. Location or Tow Balti | onmen on (Street a n, State) 2 more ause(s) an ate and pla 29d. I July | tal tem nd Number or R 324 East MD d manner as sta ce, and due to t Date signed (M | tral Route Number, City t Oliver St. atted. he cause(s) |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ,2012 Physician/ July Jozel Short 9:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1700 Edmondson Avenue Apt.310 Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 Birtholace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral Director** 249-42-4762 1 🛛 M 2 🗆 F 84 04/26/28 S.Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò should be filed within 72 hours after death with the and Mental Hygiene.

is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be a Funeral 1700 Edmondson Avenue Apt.310 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Balto. 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) City Water Dept. Driver 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Boney Short Louisa Lucas permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3007 Mayfield Ave.Baltimore Maryland 21213 Charissa Jocelyn Hill Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/12 |Landsdowne, MD. Mt.Zion Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home Rd.Baltimore_MD.21206 4210 Belair as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. D Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Pregnant at time of death signed by the at d be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No **Director:** After this certificate has d in by the funeral director, page 2. or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 2 No М 1 Yes Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital the Funeral Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier dical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar ause of death (Item 23a) (Type, Print)

| | | | Please Typ amend 1t | e or Print in Black Indelible Ink, Ensure em 20b per fh g930 8-14-12 vt ate of Maryland / Department of Health and | e All Copies Are Legible. | | |
|--|--|-------------------------------|--|---|---|--|--|
| | | 1 | For State Registrar | Certificate of Death | Reg. No. 2012 22192 | | |
| | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) | Scott | 2. Date of Death Month Day Year 12 9 104 M | | |
| | Medic Examin | | 4a. Facility Name (if not institution, give street a | nd number) 45. City, Toyln, or Location of De | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 214 · 754 · 25 + 7 1 □ M 2 | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours M | | | |
| | /land f show ed at | tor | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Location | 10d. Inside City Limits | | |
| | h the Man a or 28a- be notifie | al Director | MD Battimor 10e. Street and Number 7130 N. Alter S | 10f. Zin Code | 1 ☐ Yes 2 🗓 No 10g. Citizen of What Country? | | |
| 36 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married | as Decedent Ever in U.S. med Forces? ☐ Yes 2 No (res, Give 1 ☐ Yes 2 No Specify: | (Specify Yes or No- 14. Race - American Indian, | | |
| 21215-0036 | in 72 hours e. nan "natura Medical E | Completed by | 15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12) | (Give kind of work done during most of villege (1-4 or 5+) | working 16b. Kind of Business/Industry | | |
| and 21 | oe filed with intal Hygien ked other t | To Be C | 12th grade 17. Father's Name (First, Middle, Last) Trank Johnson | illege (1-4 or 5-4) I year Branch Chief 18. Mother's Salli | Name (First, Middle, Maiden Surname) | | |
| Maryland | 12 should bath and Me 27 is mark | | 19a. Informant's Name/Relationship (Type, Pri De Mitria Rene Lynch | | Rural Route Number, City or Town, State, Zip Code) | | |
| Baltimore, | Page 1 and nent of Hea ant: If item ury or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) Avivative National 8 | Date to 20c. Location - City or Town, State -22-12 Animaton, VA | | |
| Balti | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility | laughn C. areen Duncai services Rundall Stown MD 21133 | | |
| | Physician/ | | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (final disease or condition | ns that caused the death. Do not enter the mode of dying, such as card se on each line. Motastatic Recort Concrete | diac or respiratory arrest, Approximate Interval Between Onset and Death | | |
| | Medical Examiner | | resulting in death) | Due to (or as a consequence of): | | | |
| | executed an and rial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c | Due to (or as a consequence of): | | | |
| 09 | tte be exec hysician ai the burial-t | I — I | resulting in death) Last | Due to (or as a consequence of): | | | |
| Box 68760 | iaw requires that the death certificate be executed ias been signed by the attending physician and 2 2 should be detached for use as the burial-transit | Completed by Physician/Medica | in the past 12 months? | yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) | 23d. Date of delivery Month Day Year | | |
| s, P.O. | res that the signed by d be detac | d by Ph | Part II. Other significant conditions contribu | ting to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| of Vital Records, | The law require ate has been si page 2 should I | omplete | | | 24a. Was an autopsy performed? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) | | |
| tal B | cian: Tl ertificat ector, p | Be | 25. Was case referred to medical examiner? | 26. Place of Death (C | | | |
| f Vii | Physic rthis co | 잍 | 1 L Yes 2 A No | 1) Inpatient 2 ER/Outpatient 3 DOA 4 Nursin | ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | | |
| ion | Attending Physician: or death. ector. After this certific by the funeral director, | Certificate: | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | (Month, Ďay, Year) injury work? M 1 ☐ Yes 2 ☐ No e. Place of Injury - At home, farm, street, factory, office | 28f, Location (Street and Number or Rural Route Number, | | |
| Signatural Sig | | | | | | | |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: | Medical | (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Practical Control on the control of th | ctitioner: To the best of my knowledge, death occurred at the time, date a | red at the time, date and place, and due to the cause(s) and manner stated. nd place, and due to the cause(s) and manner as stated. | | |
| | To the virth com | | 29b. Signature and title of certifier | 29c, License number T NPI#1015 2330 | | | |
| | Ø | | 30. Name and address of person who comple | ted cacse of coath (item (3a) (Type, Print) | more MD 21287 | | |
| | Sta | | 31. Date filed (Worth, Day Sear) 2 | 32. Registrar's gignature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | e of Maryland / Depart | | Mental Hygie | ene 2012 | 22101 |
|--|---|--|---|--|--|---|
| | State Registrar | Certif | ficate of Death | Reg | , No. 2012 | 6610 |
| Physician/ Medical | 1. Decedent's Name (First, Middle, Last) Teresa Ann | Schulze | | 2. Date of Death Month 07 | 09 2012 | 3. Time of Death 3:30 A M |
| Examiner | 4a. Facility Name (if not institution, give street and | | b. City, Town, or Location of Death | | 4c. County of Death | |
| Funeral | 7549 Baltimore Annapol 5. Social Security Number 6. Sex | | Glen Burnie | 8. Date of Birth | Anne Aru | andel ace (State or Foreign |
| Director | 216-34-8437 1□M2X | F Yrs. M | lonths Days Hours Min. | (Month, Day, Ye | ear) Countr | y) |
| at at | Usual Residence of Decedent 10a. State 10b. County | 76 | on | 12/09/1 | | Virginia Virginia |
| Important: It tem 2.1 is marked other than "hadral", or tems 2.3a or 22a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | MD Anne Arund | | | | 10 | d. Inside City Limits 1 Yes 2 No |
| Dir | 10e. Street and Number | | 10f. Zip Code | 100 | g. Citizen of What Countr | |
| Funeral Director | 7549 Baltimore Annap | olis Boulevard | 21060 | | USA | |
| | Arme | Pecedent Ever in U.S. 13. Was If Ye | Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - America Black, White, et | |
| Completed by | 1 Never Married 2 X Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | es 21X No | Yes 2 No Specify: | | Specify | |
| lete | 15. Decedent's Education | 16a. Decedent | 's Usual Occupation | 16 | Whit | |
| omp | | | f of work done during most of work OT use retired) | ing | | , |
| Be C | 12 | | Homemaker | | Own Home | <u> </u> |
| To E | 17. Father's Name (First, Middle, Last) Giacomo Polett | ł | | e (First, Middle, Maid | den Surname) | |
| | 19a. Informant's Name/Relationship (Type, Print) | 1 | Mari | | ty or Town State Zin Co | ada) |
| П | Mr. Conrad L. Schulze, | nusband | Baltimore Annapo | | | * |
| П | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal | 20b. Place of Disposition | | | c. Location - City or Tow | |
| | 4 Donation 5 X Other (Specify) Ento | nbment Glen Haver | n Mem. Park 07/ | 13/2012 | Glen Bur | |
| | 21. Signature of Funeral So vice Incensee | M01121 22. Na | ame and Address of Facility Sin | gleton Fu | neral & Cre | mation |
| | 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause o | , DC1 | | | | Approximate |
| é, | Immediate Cause (Final disease or condition | | Miss- liver | | | nterval Between Onset and Death |
| al er | resulting in death) a | to (or as a consequence of): | 7 40315 - 1 (000 | | | |
| | Sequentially list conditions, b. | 4-1 | | | | |
| J i | Cause (Disease or injury | to (or as a consequence of): | | | | |
| Exa | that initiated events c. | to (or as a consequence of): | | | | |
| dical Examiner | d | | | | | |
| Physician/Me | IF FEMALE: 23c. If yes | outcome of pregnancy | | | 1 | |
| iciar | in the past 12 months? | ive Birth 2 🗌 Fetal death 3 🔲 Ec | ctopic pregnancy ther (specify) | | 23d. Date of delivery Month D | v Pay Year |
| hysi | 9 Unknown 9 U | nknown | | | | |
| ρ | Part II. Other significant conditions contributing | o death but not resulting in the unde | rlying cause given in Part I. | | co use contribute to the | |
| sted | | | | 1 🗌 Yes | 2 No 3 □ Proba | bly 4 🗌 Unknown |
| Completed | | | | 24a. Was an autopsy | prior to com | y findings available pletion of cause of |
| | 25. Was case referred to medical | | | performed | | ₽No |
| To Be | examiner? Hospital: | Innation 2 ED/O | 26. Place of Death (Check | | 0 0 0 0 0 | |
| | 27. Manner of Death 28a. D | Inpatient 2 ER/Outpatient 3 | 28c. Injury at 2 Nursing Ho | me 5 Residence 28d. Describe how in | e 6 Other (Specify) | |
| Certificate: | 2 Accident Investigation | fonth, Day, Year) injury | work? 1 ☐ Yes 2 ☐ No | | | |
| Certi | | ace of Injury - At home, farm, street, ilding, etc. (Specify) | factory, office | 28f. Location (Street City or Town, St. | t and Number or Rural Retate) | oute Number, |
| Medical | 29a. Certifier 1 Certifying Physician: To the | e best of my knowledge, death occu | urred at the time, date and place, an | nd due to the cause/s | s) and manner as stated | |
| Medi | (Check 2 L. Medical Examiner: On the | basis of examination and/or investigatiner: To the best of my knowledge, dea | ion, in my opinion, death occurred at | the time date and nls | ace, and due to the cause | ole) and manner stated |
| _ | 29b. Signature and title of centifier | | 29c. License number | | Date signed (Month, Da | |
| | 124/14 | my M | 1 09 115/ | | July, 10, | 7017 |
| | 30. Name and address of person who completed of | ause of death (Item 23a) (Type, Print) | od ul Clen | Bune | mp 200 | 161 |
| ate | 31. Date filed (Mor₩), ♥all, Year) | legistrar's Signature | 2.1 | | / 10 | |
| o6-2011 | JUL 1 3 2012 / | June B. Gar | | | | |
| 30 2011 | | | 4.4 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death June Day Thomas 2012 Year 30 1:26 Ам 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HCR Manor Care Upper Marlboro Prince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Month, Day, Year) 926 226-42-7684 86 Yrs Mar. Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Upper Marlboro Prince George's 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Largo Road 20774 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 ☐ Yes 2 K No Specify: **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Thomas John C. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 3502 Pearl Dr., #202, Capitol Heights, MD Denise Macklin - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Stafford Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 07-07-2012 Stafford, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one was every ach line. al Between Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Ph, sician/ Medical Examiner

physician and the burial-transit

attending ph

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certificate

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n 24 hours atter occur... ne Funeral Director: After th

Be

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Certificate:

Medical

Physician:

Hospital or Attending

Physician/

Medical

Examiner

Funeral

Director

show

28a-f

Il Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be

within 72 hours after

Page 1 and 2 should be filed vent of Health and Mental Hygant; If item 27 is marked oth

Ith and Mental F 27 is marked of traumatic ever

other

ō

Department of Important: If any injury or once.

Maryland 21215-0036

Baltimore.

Division of Vital Records, P.O. Box 68760

notified at

Director

Funeral

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Completed

Be

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MD

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months' g Unknown Completed by

24a. Was an autopsy performe Yes 2

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 6

| 25. Was case referred examiner? | |
|--|----------|
| 27. Manner of Death 1 Natural 2 Accident | 5 Pendin |

Suicide

4 Homicide

5 Pending Investigation 6 Could not be

determined

28a. Date of injury (Month, Day, Year)

Hospital

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 🗆 Yes 2 🖵 76

26. Place of Death (Check only one)

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of gertific

Babi lah

m 23a) (Type, Print) 9410 Awhapolis Rd#306

State

| Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible |
|--|
| State of Manyland / Department of Health and Montal Hygiene |

| | | | For | State of Maryla | | | | Mental Hy | giene | | |
|--|--|------------------|---|---|---|---|--------------------------------|------------------------------|-------------------------|---------------|---------------------------------|
| | | _ | State Registrar | | Cer | tificate of L | Death | | Reg. No. 2 | 112 | 22/95 |
| P | hysicia | n/ | 1. Decedent's Name (First, Middle, Last) | ilmana Ta | | | | Date of De Month | 9, 2012 | Year | 3. Time of Death |
| | Medic Examin | al | Charles John Treff 4a. Facility Name (if not institution, give st. | | | 4h City Town or | Location of Death | | | u of Double | 2:05 P.M |
| e / | | eı | Upper Chesapeake M | Medical Cente | | Bel Air | | | 4c. County Har | ford | |
| | uneral rector | | 5. Social Security Number 6. Sex 212-12-4729 1 | 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | ıy, Year) | Count | ** |
| 100 | | | Usual Residence of Decedent | 90 | | | | Dec. 3 | , 1921 | Mary | yland |
| yland | f sho | tor | 10a. State 10b. County | 10c. C | ity, Town or Loc | ation | | | | 10 | 0d. Inside City Limits |
| e Mar | . 28a- notifie | Sire | Maryland Harford 10e. Street and Number | E | Bel Air | Training in | | | | | 1 Yes 2 No |
| vith th | ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral Director | 7 Lake Drive | | | 10f. Zip Code 21014 | | | 10g. Citizen of USA | What Coun | try? |
| leath v | items er mu | Fune | | 2. Was Decedent Ever in U | .S. 13. V | las Decedent of Hi Yes, specify Cuba | spanic Origin? (Sp | ecify Yes or No- | 14. Rac | ce - America | |
| affer d | l", or i camin | by | 1 Never Married 2 Married | Armed Forces? 1 Yes 2 □ No If Yes, Give | | Yes, specify Cuba | | Hican, etc.) | Bla Specify | ck, White, e | |
| 3 Sours | atura cal E | Completed | 3 Widowed 4 □ Divorced 15. Decedent's Educ | Year or Dates. | 16a Deced | ent's Usual Occup | ation | | | 7 12 1.L. | |
| לב 172 ה 18. | an "n Medi | dm | (Specify only highest grade Elementary/Secondary (0-12) | | (Give k | ind of work done of NOT use retired) | luring most of work | 9 | 16b. Kind of B | | |
| Vgiene | her th t, the | | 12 | | Elec | ctronic 1 | lechnicia | n | Teleca | munio | cations |
| Maryland 21215-0036 2 should be filed within 72 hours after Ith and Mental Hygiene. | c even | To Be | 17. Father's Name (First, Middle, Last) Charles John Treff | inger Sr. | | | 18. Mother's Nam Mary (n | | _ | e) | |
| ary nould h | mari | | 19a. Informant's Name/Relationship (Type | | 19b. Mailin | g Address (Street a | | | | State Zin C | Inde) |
| | n 27 is er tra | | Charleen Treffinger | / Daughter | 1. | ake Drive | | | | | |
| Saltimore, bermit. Page 1 and Department of Hea | If iten | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R | emoval from State | Place of Dispos cemetery, crem | atory or other plac | e) | Date | 20c. Location | , | |
| ti. Pag rtment | rtant: njury o | | 4 ☐ Donation 5 ☐ Other (Specify) | Bel | | emorial (| | | | | aryland |
| Depa | Important: If it any injury or o' once. | | 21. Signature of Funeral Service Licensee | ich | | Name and Addres | | | Funeral Maryla | | |
| | | | 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one | ations that caused the dea cause on each line. | th. Do not ente | r the mode of dying | g, such as cardiac | or respiratory ar | rest, | | Approximate Interval Between |
| - | ician/ edical | | Immediate Cause (Final disease or condition resulting in death) | And | | ncephali | opathy | | | | Onset and Death |
| | miner | | | Due to (or as a consec | | arres | ÷ | | | | |
| | + | iner | if any, leading to immediate cause. Enter Underlying | Due to (or as a consec | THE RESERVE AND ADDRESS OF THE PARTY OF THE | arreg | | | | \neg | |
| cuted | and transi | xam | Cause (Disease or injury that initiated events c. resulting in death) Last | Due to (or as a consec | | | | | | - | |
| be executed | ohysician and the burial-transit | dical Examine | resulting in death) Last | Due to (of as a consec | quence oi). | | | | | | |
| ficate b | g phys | | d. | | | | | | T. | | |
| certifica | r use | an/N | 23b. Was decedent pregnant | c. If yes, outcome of pregn 1 Live Birth 2 Fet | | Ectopic pregnance | v | | 23d. Da | ate of delive | ery |
| box death | the att | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregnant at time of Unknown | | Other (specify) | , | | Mo | onth | Day Year |
| | ed by detac | Ph | Part II. Other significant conditions cont | ributing to death but not re | sulting in the ur | nderlying cause giv | en in Part I. | 23e. Did to | obacco use cont | ribute to the | e cause of death? |
| S, F | n signe | ed by | Coronary arter | y disease | | | | 1 🗆 | Yes 2 No | 3 🗆 Prob | pably 4 🗗 Unknown |
| w requ | s beer 2 shou | Completed | | | | | | 24a. Was | | | sy findings available |
| Hecords, The law requires | ate ha | Som | | | | | | autor perfo | rmed? | death? | _ |
| VITAII iysician: | ector, | Be | 25. Was case referred to medical examiner? | spital: | | Lou | ace of Death (Chec | k only one) | | | |
| Physic | this ral dir | ٦. | 1 Yes 2 No | 1 Inpatient 2 2 | ER/Outpatient | | 4 L Nursing Ho | | dence 6 Oth | 1.7 | |
| on or Iding Pl | : After e fune | cate | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | injury | 28c. Injury work' M 1 🗆 | | 28d. Describe r | now injury occurr | ed | |
| r Attendir er death. | rector by th | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Specif | | et, factory, office | | 28f. Location (S | Street and Numb | er or Rural i | Route Number, |
| spital o | eral D | edical C | 29a. Certifier 1 V Certifying Physici | an: To the best of my know | | courred at the time | date and place a | - | | ner as state | id |
| DIMISION OF VITAL RECORDS, F.O. BOX 05/00. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. | the Fur | Σ | (Check 2 Medical Examine only one) 3 Certifying Nurse I | r: On the basis of examination of the best of | on and/or investi | gation, in my opinio | n, death occurred a | t the time, date a | ind place, and du | e to the caus | se(s) and manner stated. |
| P S S | 9 00 | | 29b. Signature and title of certifier | | | 29c. License | number 342_0 | | 29d. Date signed July 9 | | - |
| ļ | | | 30. Name and address of person who com | | m 23a) (Tvna 🕒 | | -420 | | - 417 | اں۔ ر | |
| 1 | | | Sid 2. Kharal | Soo upper | chesape | ike Dr. | Beldir | MP 2101 | 4 | | |
| | Stat egistra | _ | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ature | , | | <u> </u> | | | |
| , n | egistra | " | JUL 1 3 2012 | been B. | gare | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11.15PM EDWARD E. TAYLOR 07 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN HOSPITA BALTIMORE mD Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 **X** M 2 □ F Months Hours (Month, Day, Year 213-28-9802 VIRGINIA Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No PARKVILLE BALTIMORE MD 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21234 USA 8599 MORVEN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. K Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced KOREA 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US POSTAL SERVICE GENERAL FOREMAN 12TH GRADE Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HELENE FUSCHI THOMAS TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 HIDDEN BROOK CT. ABINGDON, MD 21009 SHAWN TAYLOR/SON 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 7/13/2012 PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Censee MO1159 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 29a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final SPIRATION 9 NEYMONIA Physician/ disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** 45PH 441A Sequentially list conditions, Examine Ducito (or as a consequence of rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the bur P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforn Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Gertifying Nursus Frantisciers to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) RES 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 5601 LOCH RAVEN AMEEP SEHUAL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ELIZABETH NAN VICKERS 11:30 P.M JULY 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OAK CREST CARE CENTER PARKVILLE BALTIMORE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Director 1 □ M 2 🗓 F 218-12-4578 88 1/4/1924 MARYLAND Usual Residence of Dece 28a-f shov 10a. State 10b County 10c. City, Town or Location aţ 10d. Inside City Limits Director the Medical Examiner must be notified MD BALTIMORE PARKVILLE 1 Yes 2 X No 10e. Street and Number 0 10g. Citizen of What Country? 23a Funeral 8810 WALTHER BLVD. APT. 3612 21234 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Black, White, etc. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) REGISTERED NURSE HOSPITAL YEARS Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other treasment. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM A. LEIMBACH ANNE O'CONNOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH VICKERS/SON 5284 SCHALK ROAD NUMBER 1 MANCHESTER. MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriaj 2XI Cremation 3 ☐ Removal from State 30 pm METRO CREMATORY, 4 Donation 5 Other (Specify) INC. 7/13/2012 CATONSVILLE, MD Signature of Funeral Service Licensee MO1/139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, he ding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 i Month Year Pregnant at time of death Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAO, CHF Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 🗌 No Yes Hospital o: Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes ျ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 D Other (Specify) Certificate: 27. Manner of ath 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at I Director: After the 28d. Describe how injury occurred 5 Pending work 2 🗌 No hours after death Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral L

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 29d. Date signed (Month, Day, Year) CRAP, MIN who completed cause of death (Item 23a) (Type, Print) (RNP 8800 Watther Blud Packville MD 21234 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 8 per fh g931 9/28/12 er hicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death N/A muher MOST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7/7/12 Birthplace (State or Foreign Country) **Funeral** Min Hours 7/6/1 **Director** 1 □ M 2**X** F MD 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 St. Stephen Court - Apt.C3 21217 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Specifican Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Amer. other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) Wayne Wyatt 18. Mother's Name (First, Middle, Maiden Surname)
Marquita Chanae Nealy Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Wyatt/Father 2409 St. Stephen Ct, Balt., MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem 20c. Location - City or Town, State Date Department of Hamportant: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Balt.,MD 7/18/12 4 Donation 5 Other (Special 22. Name and Address of FacilityHari P. Close F.Svs, pa 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fund al Service 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) Brnou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mee

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20a. b. per FH, G929, 7/20/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ deno 150N AMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5210 READY Baltimore AVENUE 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Davs 215-30-6075 **Director** 1 ₺ M 2 🗆 F 76 NC 04-21-1936 28a-f show 10a. State 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Evantiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5210 4VENUE 21212 USA EADY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) UNIVERSITY of MD 2 TORE KEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SYLVESTER 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 l jury or other tra ELONIA RIEND Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot Trintey Ceine Cetyplace) 1 Burial 2 Cremation 3 Removal from State Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) /19/2012 22. Name and Address of Facility Vaughn GREENE FUNERAL SCVS PA 21. Signature of Funeral Service Licenses once. Balto, Md. 21212 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ StomACH 24CCR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examin attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown 2 No To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name eath (Item 23a) (Type, Print) 31. Date filed (Month, Day Ye JUL 13 20 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Brightview Avondell Bel Air If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Min. Hours 234-46-8533 Country Director 1 □ M 2 1 F 79 02/03/1933 WV Usual Residence of Decedent 28e-f ehov permit, Pege 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Heelth end Mental Hygiene. Importent: If item 27 is marked other then "neture!", or items 23e or 28e-f eho any injury or other traumetic event, the Maries I Examines must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Fallston 1 Yes 2 No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 21047 2510 Rochelle Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 4^{College (1-4 or 5+)} Elementary/Secondary (0-12) Defense Contractor Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) Elinor Ambrose 17. Father's Name (First, Middle, Last) ၉ John Kovach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mearns - Daughter 2510 Rochelle Dr., Fallston, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 07/12/2012 Glen Burnie, MD 21. Signature of Funeral Service License Schimunek Funeral Home 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Entey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Indentity in Cause (Disease or injury Due to (or as a consequence of): Examil e Hospital or Attending Physicien: The lew requires thet the deeth certificate be executed in 24 hours after deeth.
I 24 hours after deeth.
Funerel Director: After this certificate has been signed by the ettending physicien end letely filled in by the funeral director, page 2 should be deteched for use as the burlel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Year 9 Linknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a, Was an 2 No 1 Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2- No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

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completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene

Cortificate of Death 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 3:00 P M Clara Louise Wolfe 2012 30 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2114 Old Edgewood Road Harford Edgewood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 219-22-7459 Director 1 M 2 XF 85 May 22, 1927 Maryland Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland notified at Director 1 🗌 Yes 2 🔀 No Harford Aberdeen MD 10f. Zip Code 5 10e. Street and Number 10g, Citizen of What Country? ms 23a or must be n Funeral 1823 Tower Road USA 21001 iral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bar/Restaurant Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clara Elizabeth Cochran Clyde (nmn) Isennock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Robin A. Taylor / Daughter 909 Averill Rd., Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 0 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Air Memorial Gdn. 7-6-12 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Si ture of Funeral Service 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Mama 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CORONORY ARTERY PISCASE Sequentially list conditions Examine any, reading to immediate cause. Enter Underlying Cause (Disease or injury HYPERTENSION physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as 1 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No detached for Month Year Day 1 Yes 2 G g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE PULMOWARY DISTAST Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed MULTUNFARCT DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy PARKINSONION SYNPROME 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Phes 2nd Hospital: 1 ☐ Yes 2 🐼 No မ 1 Inpatient 2 ER/Outpatient 3 DOA - 6 XOther (Specify) Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral C Hospital Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) Sew Nouvalos D08096 DOLY 3, 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FULFORD AVE. BELAIR, MP 21014 NDAGN NOWAKOWSKI MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 4, Physician/ Louis Yates Charles 2012 5:10 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Valley Nursing & Rehabilitation Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days OCL. T4 Year)1925 1**x** M 2 □ F Hours 86 195-12-7975 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 1 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ıral", or items 23a o Examiner must be 20902 United States 10312 Insley St. Funeral "natural", or items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 ĀNo Specify Yes, Give 3 ▼ Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) Callage (1-4 or 5+) Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Cecelia Dorang Benjamin Aloyius Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10811 Littleford Ln. Kensington, MD 20895 Carol Yates (daughter) Baltimore, Jul.Date 12. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ACremation 3 Removal from State cemetery, crematory or other place) Beltsville, MD. Chesapeake Crematory 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Fund a Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIO PULMONARY ARREST resulting in death) Medical Due to (or as a consequence of) Examiner ADVANCED DEMENTIA Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examine anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No i signed by the a ld be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed' 1 🗌 Yes 2 🗎 No io the Hospital or Attending Physician: Τη within 24 hours after death.

To the Funeral Director, After this certificate completed filled in tw the ε certificate Yes 217 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending injury work? 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title certifie July 10, 2012

Registrar

DHMH 17 Rev 7/2009

State

Name and addr.

MARICH

31. Date filed (Month,

MX

10110 MOLECULAR DR. #206, ROCKVILLE, MD

20850

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THERESA A.

Day, Ye

13

ss of person who completed cause of death (Item 23a) (Type, Print)

MATAS M.D.,

32. Registra 's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#26, perPHYS, G929, 7713/2012, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:20 Рм Mary Louise Zaworski 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2509 Atlantic Ave., Unit #3 Ocean City Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days (Month, Day, Year) Hours Country) 160-48-3210 **Director** 1 □ M 2 🗓 F March 10, 1943 Pennsylvania 69 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 🕅 No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 items 23a United States 6806 Bellona Ave. death 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygene. Important: If item 27 is marked other the any injury or other traumment. "natural", or iter Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married 2 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Mission Helpers Sacred Ht church ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Casimir Zaworski Grace Beitler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 W. Joppa Rd. Towson, MD Sr. Loretta Cornell, MHSH/guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery July 7,2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Mitchell Wiedereld Funeral Home, Inc 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) as a consequence of) Examiner OV onavo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician defacted for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Day 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ana Division of Vital Records, 1 Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an • Hospital or Attending Physician; The law 1 24 hours after death.
• Funeral Director: After this certificate has b. autopsy perforr Scoli 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be summer 1 ☐ Yes 2 ☑ No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6X Other (Specify) residence 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Matural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Dav. Year) 32. Regis Registrar

| 2-04987 | | Ple | | | | | | | | | opies Are L | egibl | e. | |
|--|----------------|---|--------------------|------------------------|------------------|--------------|------------|----------------|---------------|--------------------------|------------------------------------|----------------------------|----------------------|------------------------------|
| Susan Lorraine A | | | Sta | ite of Mary | land i | | | | | nd Ment | tal Hygiene | | 201 | 2 2220 |
| | | l- For State Registrar | | | | Cert | ifica | te of De | eath | | | Reg. No | 201 | |
| Physiciar | - | 1. Decedent's Nam | | | | | | | | | 2. Date of D Month July 3, 2 | | Year | 3. Time of Death 1342 hrs |
| Medical Examin | | Susan I | | e Adkins | | - | | 145.0 | 1. T | or Location o | | | c. County of Death | |
| | | 4a. Facility Name (3824 15th S | | , give street and | number) | | | | | ke Beach | | | Calvert | |
| Formand | 4 | 5. Social Security N | | 5. Sex | [7 Ag | (In yrs. la | st hirtho | | Under 1 Ye | | | | 1/DD/YYYY) 9. Bir | thplace (State or |
| Funeral Director | | _ | | | | | ot Dirtire | М | onths Da | | Min | 6/19 | Foreig | untry) MD |
| | - | 212-96-7 Usual Residence o | 772 | 1 M 2 X F | | 49 | | Yrs. | | | 12/1 | .0/ 19 | 702 00 | unity) TID |
| вия | | 10a. State | 10b. County | | | 10c. City, | Town or | Location | | | | | | 10d. Inside City Limits |
| | _ | MD | Calve | rt | | | | C | hesan | eake l | Reach | | | 1 X Yes 2 No |
| Maryland 28a-f show d at once. | 읽 | 10e. Street and Nu | | 1 L | | | | | . Zip Code | care. | De u eii | 10g. Ci | tizen of What Cour | ntry? |
| 5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", ar items 23a or 28a-f sho the Medical Examiner must be notified at once. | Director | 3824 15 | th Stro | ot | | | | 2 | 0732 | | | | USA | |
| with t | ᡖ | 11. Marital Status | LII SLIE | | ecedent | Ever in U.S | S | 13. Was De | cedent of H | | in? (Specify Yes or | No- | 14. Race - Ameri | can Indian, Black, |
| eath item | Funeral | 1 X Never Marri | ed 2 Ma | rried Armed | Forces? | X No | | If Yes, sp | pecify Cuba | an, Mexican, | Puerto Rican, etc.) | | White, etc. | |
| fer a | S C | 3 Widowed | 4 Divo | rced If Yes, Give Y | | 140 | | 1 Yes | 2 🗓 N | o specify: | | | Specify: V | Vhite |
| ours a | | 15. Decedent's E | ducation (Speci | fy only highest gr | ade com | pleted) | | ecedent's Us | | | kind of work done | 16b. | Kind of Business/I | ndustry |
| 6 172 h | Completed | Elementary/Seco | | College | (1-4 or 5 | 5+) | | | - | | aos romou, | | 0 | |
|)03 within lene. or the | 틹 | | 10 | | | | Tr | ruck D | river | | | | Construc | tion |
| Hygin Hygin the | | 17. Father's Name | | | ٦ | | | | | | s Name (First, Middle bara Jean | | • | |
| 21215-0036 Indid be filed within 7 In rital Hygiena marked other than c event, the Medica | 8 | Harold 19a. Informant's Na | | | or. | | 10h | Mailinu Add | race /Stra | | ber or Rural Route in | | | Zip Code) |
| D 2 shoul and h |] ٢ | | | | - hor | | | | | | ive, Ches | | | |
| and 2 and 2 ealth tem 2 | ŀ | Barbara 20a. Method of Dis | | 1115, 110 | LHer | 20b. P | | Disposition | | | Date Date | | Location - City or | |
| Baltimore, MD 2121 bernit. Pages I and 2 should be fi Department of Health and N. mtal I important: If item 27 is marked important: When transmatic very | - | 1 Burial 2 | Cremation | 3 Removal | from Sta | 110 | | y or other pl | | | 07 06 201 | ۱, | 1 1 | - T7 A |
| ti. Pa | ŀ | 4 Donation 5 21 ₄ Signature of Fu | Other Spe | ecify: | _ | Met | ropo. | litan C | | | 07-06-201 | | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and N 'ntal Hygene. Important: If item 27 is marked other than "natural", ar items 23a or 28a-f sho injury ar atther traumatic event, the Medical Examiner must be notified at once. | | 21 Signature of Fu | D C | icensee | M | 00715 | | | | | Rausch Fi | | | P.A. 20736 |
| Physician | - | <i>ULLUGAN I</i> 23a, Part I. Enter th | ne disease, or o | omplications that | rn caused | the death. | Do not | enter the mo | ode of dying | natilio g, such as ca | ardiac or respiratory | arrest, sh | ock, or heart | Approximate Interval |
| /Medical | J | failure. List or | ly one cause of | n each line. | | | | | | | | | | Between Onset and Death |
| Examiner | - | Immediate Cause (or condition resulti | | a. Cardi Due to (or as | | |): | | | | | | | |
| 4-48 | - | Sequentially list co | nditions | b | | | | | | | | | | |
| | [필 | if any, leading to in cause. Enter Under | nmediate | Due to (or as | a conse | quence of) |): | | | | | | | |
| | Examiner | (Disease or injury t events resulting in | hat initiated | Due to (or as | a conse | quence of) |): | | | | | | | |
| | | evense resulting in | dodiny Last | d. | | | | | | | | | | 2 |
| | <u> </u> | X UNPENDED | | AMENDE | 23a | ,27,p | er i | ne,g92 | 29 7-2 | 27-12 | sm | | | |
| Box 68760, death certificate be exhe attending physician defor use as the burial | | IF FEMALE: | - | | s, outcon | ne of pregn | ancy | | | | | 23 | 3d. Date of delivery | , |
| 687 ertific | an i | 23b. Was decedent past 12 months | | I LIVE | | time of doe | 2 [| Fetal de | | Ectopic | pregnancy | | Month [| Day Year |
| Sox 6 leath cer e attendi | Sic | 1 Yes 2 | No 9 🗸 Unkr | | gnantat known | time of dea | tn 5 [| Other (| (Specify) | | 4,000,000,000,000,000 | | | |
| the d | 計 | Part II. Other sign | ficant condition | | | but not re | sulting i | in the under | lying cause | given in Pa | rt I. 23e, Di | d tobacco | use contribute to | the cause of death? |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be es hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician updately filled in by the funeral director, page 2 should be detached for use as the burial. | 2 | | | | | | | | | | 1 🔲 | Yes 2 | No 3 Prot | pably 4 🗹 Unknown |
| ords, w require | Completed by | | | | | | | | | | 24a. W | | | topsy findings available |
| law ralaw ra | 흵 | | | | | | | - | | | pe | topsy rform <u>ed</u> ? | death? | completion of cause of |
| tal Rection: The certificate ector, page | 3 | | | | | | | | | | | s 2 1 | No 1 ✓ Ye | es 2 No |
| Vital Recc ysician: The lav his certificate ha director, page 2 | ă۱ | 25. Was case refer examiner? | red to medical | Hospital: | Inpatie | -1 2 | EB/Out | patient 3 | DOA | Other | (Check only one) Nursing Home 5 | Posid | anco 6 Othor | - Saana |
| Physic Physic er this rral dire | ٥ | 1 Yes 27. Manner of Dea | 2 No | 4 | te of Inju | | | me of Injury | | ury at Work | | | jury occurred | . Scerie |
| n of iding Pl | <u></u> | 1 X Natural | 5 Pendi | (Moi | nth, Day,Y | | | | | Yes 2 | | | ,, | |
| Division of pipital or Attending Phouse after death. | Certification: | 2 Accident | Invest | igation | ace of In | iury - At ho | me farr | n, street, fac | ctory, office | building, etc | c. 28f. Location | n (Street | and Number or Ru | ral Route Number, City |
| Divi | 1 | 3 Suicide 4 Homicide | 6 Could deterr | not be | | , | | .,, | ,,, | | | , State) | | |
| Iospii 4 hour nuner | | 29a, Certifier | Certifying Ph | | | knowledge | e. death | occurred a | at the time. | date and pla | ice, and due to the c | ause(s) a | nd manner as state | ed. |
| Divisior To the Hospital or Attend within 24 hours after death To the Runeral Director: completely filled in by the | Medical | (Check only one) 2 | | niner:On the basi | s of exar | | | | | | curred at the time, da | | | |
| To vit | ₹ | 29b. Signature and | title of certifier | and manne | stated. | | | | 29c. Licer | se number | ··· | 29d. | Date signed (Mo | nth, Day, Year) |
| | | | inga | 4 | | | | | 0.0 | .M.E. | | Jul | y 4, 2012 | |
| | ŀ | 30. Name and add | , | | ause of d | eath (Item : | 23a) | | L | | | 1 | | |
| | | Ling Li, MD | | t Medical Ex | | | | ltimore S | treet, Ba | Itimore, N | MD 21223 | | | |
| Sta | te | 31. Date filed (Mon | | | | 's Signatur | e | park | 2.11 | | | | | |
| Registr | ar | | JUL = b | ZUIZ L | KREW | AN K | 1. 1 | grans. | | | | | | |

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registra MEND#5 per FH, 7/9/12; BWW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) **Eva Reyes**Eva Aguilera

De Aguilera 2. Date of Death 3. Time of Death 2012 Month Physician/ June 2 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Sodal/Seduby-NZn/NG-Z If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 81 10/11/1930 579-13-8255 E1 Salvador 1 □ M 2 🔀 F Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Silver Spring Maryland Montgomery 1 🌁 Yes 2 🗆 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20910 Funeral 9802 Rosensteel Avenue El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 No Specify: Salvadoran Specify: Hispanic If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 l t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Medi 72 Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) Domestic Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma Matilde Rubio မ Tomas Reyes 19a. Informant's Name/Relationship (Type, Print) Mayra E. Aguilera (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9802 Rosensteel Avenue Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Silver Spring, Maryland 1 X Burial 2 Cremation 3 Removal from State Gate Of Heaven Cemetery 6/30/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Rome ral Service Liçensee 21. Signature of Fu 4217 9th Street, N.W. Washington, D.C. 20011 40 1057 art 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Pulmonary Edema Physician/ 12 hours disease or condition resulting in death) Medical ue to (or as a consequence of); Atherosclerotic Cardiovascular Disease 20 years **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): y physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 SB the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Year Month Day Pregnant at time of death 1 Yes 2 D 9 Unknown 9 | Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ื Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No certificate 1 ☐ Yes 2 🖾 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 XNo 1 Inpatient 2 k ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 22, 2012 29c. License number D35112 CM O. Name and address of person who completed cause of death (Item 23a) (Type Print)
Paul B. Baker, MD 1500 Forest Glen Road Silver Spring, Maryland 20910

State

Registrar

31. Date filed (Month, Day, Year)

JUN 27 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DAVID ADAMS 2012 PM JUNE 10:07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WALTER REED NATIONAL MEDICAL CENTER BETHESDA 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 23, 194 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 ☐ F Days Hours 437-62-1026 Yrs Director 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 X Yes 2 No MD Prince Georges Upper Marlboro 10e. Street and Numbe 10g. Citizen of What Country? 5 10f. Zip Code must be r Funeral 3614 Halloway North 20772 USA items death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. ō ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black "natural" Completed 3 Widowed 4 Divorced 1984 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 5+US Air Force Communications event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Ulysses S. Livas Annie Adams 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 Halloway North Upper Marlboro, MD 20772 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains Ŭpper Delores White Adams/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/30/2012 Thibodaux, LA Cemetery Livas permit. 22. Name and Address of Facility Austin Royster Funeral Home 21. Signatu 20011 14th Street NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ CARDIOPULMONARY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** METASTATIC PROSTATE CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is it into a sea or iinjury Examine P that initiated events resulting in death) Last and Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical death certificate be P.O. Box 68760 nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter in the past 12 months?
1 Yes 2 No jo Dav Pregnant at time of death Month Year signed by the a d be detached f 1 Yes 2 L 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed pinous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed 1 Yes 2 No Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 **X** No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

0

JUN 27

(Check only one) 29b. Signature

RACHEL C. ROBBINS,

31. Date filed (Month, Day, Year)

MD Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

GA D67976

WALTER REED NATIONAL MEDICAL

29d. Date signed (Month, Day, Year)

200

filed within 72 hours after Maryland 21215-0036 Baltimore, The law requires that the death certificate be executed Box 68760 P.O. Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Catharine Lenore Ahalt _a. M July 5:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care & Rehabilitation Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months 1 🗆 M 2 💢 F Days Hours Min March 12,1912 100 Maryland Yrs. Director 212-38-7825 Usual Residence of Decedent al Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Rosemont Avenue 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Teacher Public School event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic even ၉ William Eugene Hauver Effie Catherine Deter 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher R. Ahalt/son 19205 Dunbridge Way, Montgomery Village, MD 20886 Department of Health Important: If item 21 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State . Paul's Lutheran July 14,2012 Myersville, Maryland 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death Immediate Cause (Final ovase Physician/ disease or condition **≱** Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease or injury that in the cause (Disease or iinjury that in the cause (Disease or iinjury that is the cause (Disease or iinjury that iinjury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Yes 2 4 ☐ Pregnant 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 certificate Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident injury work? 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗌 No 24 hours after death. Funeral Director: A Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0 completed cause of death (Item 23a) (Type, Print) MD; 300 West 9th Street, Frederick, MD 21701 Robert L. Kaufmann, 31. Date filed (Month, Day Year) 11 3 2012 32. Registrar's gnature State

Registrar

Division of Vital

Barsoumian, Markrid 6/22/12 11:48

| | | 4 | For State Registrar | State of Marylar | | artment of b tificate of L | | | | 012 | 22208 |
|--------------------------------|--|---|---|--|--|--|--|--|---|--|--|
| | Physicia | n/ | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | ath | | 3. Time of Death |
| | Medic | al | Markrid Barsoumia 4a. Facility Name (if not institution, give sti | | | 4h City Town o | r Location of Death | June 2 | 2, 2012 4c. County | of Death | 11:48 a _M |
| | Examin | er | Suburban Hospital | · · | | Bethes | | | 1 | Montgo | omery |
| | Funeral Director | | 5. Social Security Number 220-37-4878 Usual Residence of Decedent 6. Sex | 7. Age (In yrs. | last birthday) Results of the second | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Day Aug. 1 | 5, 1923 | Count | lace (State or Foreign ry) ebanon |
| | and show dat | tor | 10a. State 10b. County | 10c. Ci | ty, Town or Loc | cation | | | | 11 | Od. Inside City Limits |
| | Mary 28a-f notifie | Director | MD Montgo | omery | Rockvi | 11e | | | | | 1 Yes 2 KKNo |
| | with the 23a or st be | | 10e. Street and Number 4724 Cherry Valle | ev Drive | | 208. | 53 | | 10g. Citizen of USA | What Coun | try? |
| 980 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ed by Funeral | | 2. Was Decedent Ever in U. Armed Forces? 1 Yes, 2X No If Yes, Give Year or Dates. | l II | Vas Decedent of H | ispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Rac Blac | e - America ck, White, e : White | etc. |
| 21215-0036 | ithin 72 hour ene. • than "natu the Medical | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | | (Give F | O NOT use retired) | during most of work | <i>din</i> g | 16b. Kind of B | | lustry |
| od 2 | filed wall Hygiid I other | Be | 17. Father's Name (First, Middle, Last) | | 1 ПОШ | emaker | 18. Mother's Nam | ne (First, Middle, | | | |
| Maryland | uld be 1 Menta narked natic e | Haroutyoun Barsoumian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State | | | | | | | | | |
| | nd 2 sho ealth and m 27 is r | İ | 19a. Informant's Name/Relationship (Type Ani Iscouhi Derder | | | | and Number or Rur Valley D | | ockville | e, MD | 20853 |
| Baltimore, | Page 1 and ment of H tant; If itel ury or oth | | 20a. Method of Disposition 1 → Burial 2 Cremation 3 R 4 Decation 5 Other (Specify) | 20b. Par | Place of Dispo CEMETERY Cren RIAWN Pa | sition <i>(Name of</i> Memorial rk | June | PO12 | Rockvi | | |
| Balt | permit Depart Import any inj | | 21. Sig. atura of Funeral Service Licensee | Cole | C3 41 | Te Funer 10 Aspen | al ^r Servic Hill Roa | es, P.A d, #100 | , Rockv | ille, | MD 20853 |
| () | Physician/ | | 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition | cations that caused the dea cause on each line. Aspiration | | | ng, such as cardiac | or respiratory an | rest, | | Approximate Interval Between Onset and Death |
| | Medical Examiner | | resulting in death) | Due to (or as a consect Acute Myocar | | nfarction | n | | | | |
| | _ = | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to for as a consec | quaries off | | | | | | |
| | cate be executed physician and s the burial-transit | Examiner | Cause (Disease or injury that initiated events cresulting in death) Last | Congestive F Due to (or as a consec | | allure | | | | - | |
| 09 | te be ex hysiciar he buria | dical | L _d | | | | | | | | |
| . Box 687 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | ž | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | Sc. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown | Ectopic pregnan Other (specify) | су | | | 23d. Date of delivery Month Day Year | | |
| P.0 | that th ned by e detac | oy Ph | Part II. Other significant conditions con | tributing to death but not re | sulting in the u | nderlying cause gi | ven in Part I. | 23e. Did to | obacco use cont | ribute to th | e cause of death? |
| rds, | een sig | ted | Parkinson's Disc | ease | | | | | | | pably 4 🛣 Unknown |
| Reco | The law re ate has b page 2 sh | Somple | | | | | | 24a. Was autop perfo | osy ormed? | | esy findings available mpletion of cause of |
| ţa | sician: certific irector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: | | Toth | lace of Death (Chec | | | | |
| Division of Vital Records, P.O | nding Phys tth. : After this e funeral d | cate: To | 1 Yes 2 No Company No | 1 Inpatient 2 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injur | y at ☐ Nursing H | ome 5 Residence Residence Possible Possible Residence Re | dence 6 L. Oth | |) |
| Divisio | Hospital or Attending F 24 hours after death. Funeral Director: After etely filled in by the funer | Certificate: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At h building, etc. (Special | | eet, factory, office | | 28f. Location (S City or Tow | Street and Numb vn, State) | er or Rural | Route Number, |
| _ | he Hospit in 24 hour he Funera pletely fille | Medical | (Check 2 Medical Examine | cian: To the best of my knower: On the basis of examination of the best of the | on and/or invest | tigation, in my opini | on, death occurred a | at the time, date a | ind place, and du | e to the cau | use(s) and manner stated. |
| | To the within 2 To the comple | | 29b. Signature and title of certifier | S. Sun | | 29c. Licens | e number | | 29d. Date signe | | Day, Year) |
| _ | ي ک | | 30. Name and address of person who con Sudarshan Siva, | MD 8600 C | old Geor | rgetown I | Road, Bet | hesda, 1 | MD 20817 | 7 | |
| ı | Sta Registr | e ar | 31. Date filed (Month, Day Year) 7 20 | 12. 32. Segistrar's Sign. | ature. | arke | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROYCE F_{\bullet} BRADSHAW, JR. Medical 4a. Facility Name (if not institution) give street and number 4b. City Town, or Location of Death County of Death Examiner WICEMIC 9. Birthplace (State or Foreign Country) 1948 Maryland 7. Age (In yrs. last birthday) 8. Date of Birth Funeral April 19, 1 ▼ M 2 □ F Director 216-48-5430 64 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant, If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2731 Merritt Mill Road 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 XMarried ☐ Yes 2 【XNo 1 Yes 2 XNo Specify. White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of Maryland Department of Health and Mental Hygiene Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Juvenile Case Manager Dept. of Juvenile Serv Maryland 21 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Royce F. Bradshaw Jewel A. Stehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi E. Bradshaw (Wife) 2731 Merritt Mill Road - Salisbury, MD 21804 Baltimore 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 6/27/2012 Salisbury, Maryland Signate with a rail share being being been bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ LRUKRULA ACUTA disease or condition Medical resulting in death) Examiner TASTA Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death 2 No To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 🗡 🗎 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 Ro မ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1802 1300 173 istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:50AM 06 Medical cility Name (if not institution, give street and number) Jown, or Location of Death Examiner MO curity Number 8. Date of Birth (Month, Day, Year) last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 🗆 M 2 🗶 F Hours Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò Never Married 2 ☐ Married þ should be filed within 72 hours after and Mental Hygiene. Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) onday (0-12) Elementary/Se omec ome ma Be 17. Father's Name (First, Middle, Last) 18 Mether's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Boute Number, City or Town, State, Zip Code) rowne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funer S ice Lice Liary 601 1255100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed e to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate has 2 No 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director; After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: Natural 5 Pending death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direct building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

725

Type, Print)

completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 11:23 A M Ĭ8 2012 Sandra Marie Brown Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 8/10/1961 DC DC Director 1 🗆 M 2 🔀 F <u>579-86-6336</u> 50 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10b. Count ,10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No MD <u>Anne Arundel</u> 0denton 10f. Zip Code 10g. Citizen of What Country? Funeral <u>375 Baltimore Ave</u> 21113 US of Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No þ Black White etc. 1 🛚 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12th Sales Associate Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clyde Horace Brown Catherine Henrietta Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Brown/ Brother <u> 18706 Martins Landing Dr. Germantown,MD 20874</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Immanuel Methodist</u> 21. Signature of Furreral Service Licensee 22. Name and Address of Facility Waldorf, Maryland20601 Huntt Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicin Pulmonar disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown jo Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law ate has page 2: performed death? certificate Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 \square Pending work n 24 hours after death.

Funeral Director: Af pletely filled in by the fu 1 🗌 Yes 2 🔲 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F 3 🔲 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 001

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ $J_{\mathbf{u}\mathbf{n}\mathbf{e}}^{\mathsf{Month}}$ 20, 2012 8:50 P M Lawrence Mark Boward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Retirement Village Williamsport If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth g, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours 09/06/1923 Director 219-14-8150 88 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Bethesda 1 ¥ Yes 2 ☐ No Montgomery 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20816 Funeral 5311 Briley Place 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. X Yes 2 No World Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 ▼Widowed 4 □ Divorced War II Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Broker Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bertha Wolfinger Daniel Boward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5311 Briley Place Bethesda, MD 20816 Marjorie Boward Curl/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 6/25/2012 Rockville, Maryland 22. Name and Address of Facility Joseph Gawler's Sons LLC. 21. Signature of Funeral Se 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to himseliate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the de. th certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last ttending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 🔀 N Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After t injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation within 24 hours after de To the Funeral Director completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSPORT N. ARTIZAN ST HOWE

State

Registrar

31. Date filed (Month, Day, Year,

JUN

26

| 12-04935 | |
|----------|--|
|----------|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Paul Dakei | | I-For State Registrar | ertificate (| of Death | | Reg. No. 2012 222 |
|--|----------------|---|---|--|---------------------------------------|---|
| hysician/ Medica Examine | al | 1. Decedent's Name (First, Middle,Last) Paul Scott Baker | | | 2. Date of Dea Month July 1, 20 | Day Year 2235 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 26338 Cherry Lane | | 4b. City, Town, or Location of Hollywood | | 4c. County of Death St. Mary's |
| Funeral Director | | 5. 555.55 | s. last birthday) 40 | If Under 1 Year If Unde Months Days Hours | | irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Washington, DC |
| Maryland 28a-f show any d at once | N | | ity, Town or Loo 011ywood | d | | 10d. Inside City Limits 1 ☐ Yes 2 ☑No |
| the Maryland a or 28a-f sho | Ulrector | 10e. Street and Number 26338 Cherry Lane | | 10f. Zip Code 20636 | | 10g. Citizen of What Country? United States |
| | by Funeral | 11. Marital Status 1 Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year on Dates: | 1[| Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican Yes 2 X No specify: | , Puerto Rican, etc.) | white, etc. specify: White |
| 136 thin 72 hours ne than "natur e.Ho.l Even | Completed t | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | during | dent's Usual Occupation (Give ki g most of working life. DO NOT i Mechanic | | 16b. Kind of Business/Industry HVAC |
| 21215-0036 suld be filed within 7 Mental Hygiene marked other than c event, it we he | Be Co | 17. Father's Name (First, Middle, Last) Robert Walter Baker | | Mary | s Name (First, Middle, Ann McGove | ern |
| and 2 should be feath and Mental tem 27 is marke transments or an arrange transment or an arrange and a state or an arrange and a state or an arrange are an arrange are an arrange are an arrange are an arrange are arranged are arr | ^[| 19a. Informant's Name/Relationship (Type, Print) Stephanie Baker -wife | 2633 | 8 Cherry Lane | Hollywood, | |
| Baltimore, MD 2 pernit. Pages 1 and 2 shoul Department of Health and M Important: If Item 27 is migury or other transmenter injury or other transmenter. | | 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify | crematory of | osition (Name of cemetery, rother place) an Crematory | Date 7/3/2012 | 20c. Location - City or Town, State Alexandria, Virginia |
| Balti pernit. Departn Imports injury o | | 21. Signature of Funeral Service Licensee Day ald V. Bagwall | 22 | Donald V. Borg 4400 Powder Mi | wardt Fune 11 Road Be | eral Home, PA eltsville, Md 20705 est. shock, or heart Approximate Interval |
| Physician /Medical Examiner | | 23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (Herman et al. 1988)) | roin) I | | diac or respiratory arr | Between Onset and Death |
| | | or condition resulting in death) Due to (or as a consequence of the conditions, if any, leading to mimediate or the conditions). | | | | |
| Q | 盲 | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence | | | | |
| SO, te be executed ysician and thurial - transit | ᇹᅡ | d ☐ AMENDED 23a,27 | ,28a-f, | per me,g930 8- | -3-12 sm | |
| 376 fical fical fical | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of | 2 | Fetal death 3 Ectopio | c pregnancy | 23d. Date of delivery Month Day Year |
| res that the death certisigned by the attendin | g P | | ot resulting in the | underlying cause given in Part | | tobacco use contribute to the cause of death? es 2 No 3 Probably 4 X Unknown |
| Division of Vital Records, P.O. p. an or Attending Physician: The law requires that the ours after death. The law requires that the certificate has been signed by the funeral director, page 2 should be deach filled in by the funeral director, page 2 should be deach | ompleted | | | | per | s an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 X Yes 2 No |
| ician: 1 | Be | 25. Was case referred to medical examiner? 1 Voc. 2 No. Hospital: 1 Inpatient 2 | ER/Outpatio | 26.Place of Death ent 3 DOA Other | | Residence 6 X Other: Scene |
| n of Vi | 일 | 1. X Yes 2 No 1 Impatient 2 7. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Pending | 28b. Time | 3 J 507, 1 -1 | 28d. Describe | e how injury occurred |
| ivision Tor Attentable death Director: din by the | Certification: | 2 Accident Investigation Fd 7-1-12 3 Suicide 6 X Could not be 28e. Place of Injury - 7 | At home, farm, s | : 31 hrs treet, factory, office building, el | tc. 28f. Location or Town, | (Street and Number or Rural Route Number, City State) 26338 Cherry Ln. |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | | 4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination | Residene ledge, death occ n and/or investig | curred at the time, date and place | ce, and due to the caus | e(s) and manner as stated. and place, and due to the cause(s) |
| Tot with Tot com | Medical | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Dey, Year) July 2, 2012 |
| | ŀ | 30 Name and address of person who completed cause of death (It Theodore M. King, Jr., MD. Assistant Medica | | 900 W. Baltimore Stre | et Baltimore MD | |
| Sta | ate | Theodore M. King, Jr., MD. Assistant Medica 31. Date filed (Month, Dey, Year) 31. Registrar's Sign | | | or, Daminole, MD | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROWA 2:55 P.M. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Tate Hospice Facility Linthicum Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Days Hours Min (Month, Day, Year) 578-54-3549 Director 94 1**X** M 2 □ F Dec. 12,1917 Washington, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene, importent: If item 27 is merked other then "neturel" or them. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Colston Drive 20910 United States 12. Was Decedent Ever in U.S.
Armed Forces?
14 Yes 2 1 1942 1977
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) District of Columbia Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Director, Dept. of Recreation 5+ Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles M. Brown Bernice Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Enid Brown Marshall/Daughter Firth of Lorne Circle, Ft. Washington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 08/16/12 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service License 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final Priysician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physician end d for use es the burlal trans ause (Disease or injury or Attending Physicien: The lew requires thet the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Month Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy Director: After this certificate 2 🗌 No 1 🗌 Yes ☐ Yes 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No death Investigation filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospitel o within 24 hours af To the Funerel Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 10 u 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print)

State

Michael J. LaPenta, M.D.

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear CHARLES HERBERT BRADY /201 6:00pMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11404 Millport Circle Germantown <u>Montgomery</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number Funeral 6/9/1924ar) Days 1X M 2 | F Hours Yrs Director 298-18-4248 88 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director must be notified Germantown Montgomery 1 X Yes 2 No MD 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 11404 Millport Circle 20876 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Was Decedent Ever III 0.0.
Armed Forces?
12 Yes 2 No
If Yes, Give
Year or Dates 1943-1946 Black, White, etc. ò 1 Never Married 2 Married ģ Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha /etalurgist -NIST Government 2+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence Ackison permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. Lester A. Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8778 Suscephanna St., Lorton, VA 22079 8778 Susquehanna St., Lorton, Joesph Brady/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 6/27/2012 Hanover, MD Ardent Crematory 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service Licenses 246 N. Washington St., Rockville, MD 20850 01576 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Embolic Stroke Onset and Death Physician/ disease or condition Medical resulting in death) Due to for as a consequence of Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Coronary Artery Disease Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the buria ding physiciar Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnam 9 ☐ Unknown detached 1 ☐ Yes 2 L 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ischimic Cardiomyopathy Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy has certificate 2**X** N 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2**X** № Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge; death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/o Certifying Nurse Practioner: To the best of ny know ivestigation in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29c. License number

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

0

State

Jose De Leon Carpio, 655 Watkins Mill Road, Gaithersburg, MD 20879

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0058844

29d. Date signed (Month, Day, Year)

6/26/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Certificate of Death | | | | | | | |
|---|---|------------------|--|--|---|---|---------------------------------------|---|
| Registrar 1. Decedent's Name (First, Middle, Last) | | | Registrar | Certificate of Death | | Reg. No. 2. Date of Death 3. Time of Death | | |
| | Physicia | | Alan Charles Bouley | | | | 3, Day 201 | |
| view. | Medic Examin | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or L | Location of Death | June 2 | 4c. County | |
| | LAGITIII | ٠. | Holy Cross Hospital | Silver | Spring | | Mont | gomery |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho | day) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | Year) | Birthplace (State or Foreign Country) |
| | Director | | 011-34-6941 1 № 2 □ F 67 Yr | | | July 13 | | MA |
| | nd how at | = | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of | or Location | | | | 10d. Inside City Limits |
| | laryla 3a-f s iffied | Funeral Director | MD Montgomery Silve | er Spring | | | | 1 ☐ Yes 2 🛂 No |
| | or 2 | | 10e. Street and Number | 10f. Zip Code | | 1 | 0g. Citizen of V | What Country? |
| | s 23a | ıera | 9737 Mt. Pisgah Road, #710 | 2090 | 03 | | USA | |
| | death item ner m | Fü | Armed Forces? | Was Decedent of His If Yes, specify Cuban | spanic Origin? (Spe n, Mexican, Puerto | cify Yes or No- Rican, etc.) | | e - American Indian, ck, White, etc. |
| 30 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By a proportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by | 1 🖾 Never Married 2 🗆 Married 1 🗀 Yes 2 🖾 No If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Vear or Dates | 1 ☐ Yes 2 🔼 No | Specify: | | Specify. | White |
| 3 | | Completed | 15. Decedent's Education 16a. D | ecedent's Usual Occupat | | | 16b. Kind of B | usiness/Industry |
| 9500-G1Z1Z | | du | | Give kind of work done du fe. DO NOT use retired) | uring most of work | ng | | , |
| Z | withi giene ner th t, the | | | ysicist | | | | of Navy |
| | ital Hyad oth | To Be | 17. Father's Name (First, Middle, Last) Charles H. Bouley | | 18. Mother's Nam | e (First, Middle, N O. Chabo | | e) |
| <u>Ş</u> | 2 should be th and Men 7 is marke traumatic | - | | | | Route Number, City or Town, State, Zip Code) | | |
| Maryiand | | | | Mailing Address (Street ar 7 McCormick | | | | |
| <u>စ</u> ် | and Heal tem S | | 20a. Method of Disposition 20b. Place of D | Disposition (Name of | | | | - City or Town, State |
| <u></u> | age 1 ent of nt: If i | | | ame Cemeter | | $\frac{1}{2}$ \frac | Worcest | er. MA |
| Baltimore, | permit. Popartmi mportar iny injur | | 21. Signature of Funeral Service Ligensee | Francis Address | s Collyins | Funeral | Home I | nc. |
| | 20200 | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | Approximate |
| | tomician/ Medical | | Immediate Cause (Final | | | | | |
| | | | disease or condition resulting in death) The pattic Encephal and the pattic E | topachy | | | | |
| | Examiner | ڀ | Sequentially list conditions, b. Liver Cirrhosis | | | | | |
| | o 50 | Examiner | if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying | | | | | |
| | ate be executed hysician and the buria treesit | Exar | Cause (Disease or injury that initiated events c. Due to (or as a consequence of) | <u> </u> | | | | |
| | be ex sician buria | dical | | | | | | |
| 20/3 | icate g phy as the | ledi | | | | | | |
| 200 | death certificate he attending physed for use as the | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fetal death | 3 Ectopic pregnancy | Ectopic pregnancy | | | ate of delivery |
| POX | requires that the death certifical been signed by the attending pt should be detached for use as t | | in the past 12 months? 1 | | | | Mo | onth Day Year |
| J. | that the ned by the e detach | | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause give | en in Part I. | 23e. Did tol | pacco use cont | ribute to the cause of death? |
| | ires the signer of the signer | d by | | | | 1 □ Y | ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown | |
| Records, | The law ate has page 2 | Completed | | | | 24a. Was a | | Were autopsy findings available prior to completion of cause of |
| ec | | omy | | | | autops perfor 1 Yes | med? | death? |
| Division of Vital H | | Be C | 25. Was case referred to medical examiner? | 26. Pla | ace of Death (Chec | | 2.4.2.1101 | 100 2 2 110 |
| | Physician: this certific ral director, | 10 | Hospital: 1 X Inpatient 2 ER/Out | patient 3 DOA Other | er: 4 🗆 Nursing H | ome 5 🗌 Reside | ence 6 🗆 Oth | er (Specify) |
| | ing Pl | | 27. Manner of Death 1 Natural 1 Natural 28b. Tir (Month, Day, Year) 28b. Tir inj | ury work? | ? | 28d. Describe ho | w injury occurr | red |
| | To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this, ormpletely filled in by the funeral dir | Certificate; | 2 Accident Investigation 3 Suicide 6 Could not be | | Yes 2 No | 28f Location (St | reet and Numb | er or Rural Route Number, |
| | | Se | 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | City or Town, State) | | |
| | Hospita 24 hours Funeral stely filled | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| | To the within To the Somple | Σ | only one) 3 \square Certifying Nurse Practitioner: To the best of my knowl 29b. Signature and title of certifier | 29c. License | number | 2 | | nd (Month, Day, Year) |
| | 2 | | 1 Mhin | D | 65 30 | 5 . | June 25 | , 2012 |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Ty Nabila Khan, MD 1500 Forest Gler | oleted cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 | | | | |
| | Sta Registr | | | all | | | | |
| | | | THE APPLICATION OF THE PERSON | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month June Jacqueline Lee 18, 12:35 PM Bittner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland 230 New Hampshire Avenue Social Security Number 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XI 03/07/1947 Director 220-52-9700 65 Maryland Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD 1 X Yes 2 No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 230 New Hampshire Avenue 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Department Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Chandler, Jr. Kathleen Gloria Thomas Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Bittner / Son P.O. Box 352, Corriganville, MD 21524 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 06/22/2012 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. 21. Sign ture of Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach lin Immediate Cause (Final disease or condition Onset and Death Priysician/ ang h ol 100 Medical resulting in death) Due to (or as a cons ence of **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day Pregnant at time of death ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Llakelown filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hore To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the 29d. Date signed (Month, Day, Year) D0066439 June 19, 2012

State Registrar 31. Date filed (Month, Day, Year) 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Blanche Mavromatis, M.D., 12502 Willowbrook Rd, Ste 300, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 201^{Year} July 7:00 AM William David Chism Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 434-48-7279 77 **Director** 1 X M 2 L F 12/10/1934 Louisiana Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No St. Mary's Mechanicsville Maryland 10g. Citizen of What Country? 10e. Street and Number of Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be 1 Funeral USA 37930 E Theresa Court 20659 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 X Married Maryland 21215-0036 1 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Retired Navy (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 First Class Petty Officer US NAVY Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Louis Chism Annie Darton Chism 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Loretta Chism / Wife 37930 E Theresa Court Mechanicsville, MD 20659 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/4/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road Charlotte Hall, MD 20622 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Thrive Due to (or as a consequence of) Cause (Disease or injury use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown 4 Pregnant To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the a completely filled in by the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 622 | 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

10 the

State Registrar

22611 Avenmar Drive Leonardtown, MD 20650 Sureshbhaia H. Pate1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| Chester Joseph (| | stwell S | tate of Ma | ryland | - | ment of <i>icate</i> of | | and | Mental F | | | 20 | | 2 2221 |
|--|----------------|--|------------------------------------|--|--------------------------------|----------------------------|------------------------|-----------------------|-----------------------------|---|---------------|---------------------------|--|--|
| Physicia | | Registrar 1. Decedent's Name (First, Mid | dle,Last) | | Certin | icate or | Death | | | 2. Date of De | | | | 3. Time of Death |
| Medical Examin | er | Chester Jos | | | | | | | | Month June 20, | | Year | | 1307 hrs |
| | | 4a. Facility Name (if not institut 7104 Lory Lane | ion, give street e | nd number |) | | b. City, Tow Lanham | | ocation of Deat | th | | c. County of Prince Ge | | s |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Ag | e (In yrs. last i | birthday) | If Under 1 | _ | If Under 24Hr | | irth(MM | | 9. Birth | place (State or |
| Director | ļ | 212-08-1119 | ½ | F | 44 | Yrs. | | Days | Hours Mi | Jan ' | 17 1 | 1968 | | ntry) DC |
| any | - | Usual Residence of Decedent 10a. State 10b. County | , | | 10c. City, To | | on | | | | | | Т | 10d. Inside City Limits |
| | اة | | ice Geo | rge | Lanl | nam | | | | | | | | 1 Yes 2 XXNo |
| the Mary | Director | 10e. Street and Number 7104 Lory La | ine | | | | 10f. Zip Co | ^{ode} 706 | | | _ | izen of What SA | t Count | ry? |
| death with the Maryland or items 23a or 28a-f show must be notified at once. | Funeral | 11. Marital Status 1 Never Married 2 X | Married Arm | ned Forces' Yes 2 | Ever in U.S. ? No | | es, specify C | uban, N | Mexican, Puert | Specify Yes or N o Rican, etc.) | lo- | White, | etc. | an Indian, Black, |
| rs after ural", | ᇍ | 3 Widowed 4 D 15. Decedent's Education (Sp | ivorced If Yes, Giv or Dates: | | noleted) 16 | | | | specify: n (Give kind of | work done | 16b | Specify: Kind of Busir | | dustry |
| 136 hin 72 boure. e. than "nathedical Exa | npleted | Elementary/Secondary (0-12 | | ege (1-4 or | | during mo | | | O NOT use re | | | overm | | · |
| 215-0036 be filed within 7 intal Hygiene riced other than eat, the Medica | Be Comple | 17. Father's Name (First, Middl Chester Jose | | stwe | 11 | | | | | e (First, Middle ca Qua: | | | 1.74 | |
| MD 21 d 2 should ' Ith and Mer n 27 is man numatic ev | | 19a. Informant's Name/Relation Sondra Moor | ship (Type, Print Ce-Cres | twel | l Wife | | | | | Rural Route No | | | | Zip Code) |
| 20a. Method of Disposition Value 2 Cremation 3 Removal from State Rock Creek 2012 2 | | | | | | | | | | | | | | |
| Baltin Permit. Pr Departmen Importan injury or | H | 4 Donation 5 Other 3 21. Signature of Funeral Service | e Licensee | | | 22. N | | | | iscoe- | -Ton | ic F | une | ral Home |
| | 1 | symbolic f | | | mec | | | | | | | | | MD20601 |
| Physician Wegical Examiner | | 23á. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Gunshot Wounds (2) of Chest | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | | or condition resulting in death) Sequentially list conditions, | Due to (or b. | r as a cons | equence of): | | | | | | | | | |
| | | if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated | e c | | equence of): | | | | | | | | | |
| scuted and transit | | events resulting in death) Last | d | r as a cons | equence of): | | | | | | | | | |
| be exe sician urial - | g Gig | UNPENDED | AMENO | DED | | | | | | | | | | |
| Box 68760 death certificate be attending physical of for use as the bu | | IF FEMALE: 3b, Was decedent pregnant in past 12 months? | the 1 🔲 t | ive birth | me of pregnand | 2 Fet | al death | 3 [| Ectopic pregr | nancy | 23 | d. Date of de Month | elivery Da | ay Year |
| Box e death the atte | Š | 1 Yes 2 No 9 U | - I | Jnknown | | 3 Ott | ner (Specify | | | | | | | |
| ies that the signed by vie detach | <u>a</u> | Part II. Other significant cond | itions contribut | ting to deat | h but not resul | ting in the u | nderlying ca | use giv | en in Part I. | | _ | _ | | ne cause of death? |
| Division of Vital Records, tal or Attending Physician: The law require as after death. **I Director: After this certificate has been sided in by the funeral director, page 2 should be a second in the funeral director, page 2 should be a second in the funeral director. | Completed | | | | | | | | | perf | psy ormed? | prid dea | or to co ath? | opsy findings available mpletion of cause of |
| tal Rection: The certificate ector, page | ် မ | 25. Was case referred to medic | al | | | | 26.1 | Place of | Death (Check | 1 Yes | 2 N | lo 1 | Yes | 2 No |
| Vital hysician: this certif | ğ 2 | examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatie | ent 2 ER | /Outpatient | 3 DOA | Ot | her Nursi | ing Home 5 | Reside | ence 6 🗸 | Other: | Scene |
| ion of tending Ph eath. | | | nding Jun | Date of Inju Month, Day Y 20, 2012 | ury 281 ^(ear) 12 | b. Time of Ir 239 hrs | · · | | at Work? s 2 ✓ No | 28d. Describe Subject sh | | ury occurred | l | |
| Divisior Hospital or Attend 24 hours after death Funneral Director | Certification: | 3 Suicide 6 Co | uld not be | | njury - At home | | t, factory, of | fice buil | ding, etc. | 28f. Location or Town, 7104 Lory La | State) | | or Rura | al Route Number, City |
| | <u>ख</u> | 20a Cartifier | Physician: To the aminer: On the b | | | | | | | | | | | |
| # \$ # 8 | ĕ | 29b. Signature and title of certif | | stated. | | | | cense r | | | | Date signed | | h, Day, Year) |
| 20-9 | - | 30. Name and address of person | n who completed | d cause of c | leath (Item 23a | a) | | | | | Juil | | | |
| Arr , | | Donna M. Vincenti, N | | | cal Examin | | | ore S | treet, Balti | more, MD 2 | 1223 | | | |
| Sta Registr | ite ar | 31. Date filed (Month, Pay, Year | 7 2012 | Registra | r's Signatur | par | KN | | | - . | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24^{Day} Physician/ Bernice Lillian Cotter June 201² 10:18 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11501 Old Prospect Hill Road Prince George's Glenn Dale Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 577-18-2071 98 **Director** 1 □ M 2 X F Jan. 23, 1914 Maryland 28a-f shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Prince George's Glenn Dale 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 11501 Old Prospect Hill Road 20769 U.S.A. "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black. White, etc. þ 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer G. Longanecker Mary Eleanor Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Susan Shields - daughter 11501 Old Prospect Hill Rd., Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory 6-25-2012 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 21. Schature of Fune of Service Licensee 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician erebro vascular accident week disease or condition Medical resulting in death) **Examiner** pertension Sequentially list conditions, if any constant cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dun to for as shonsequence off y physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as guipt IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter for u in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year ed by the a Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page performe death? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after deau...
To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D37934 25/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephenie Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20170

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

| | | | Please | e Type or Pri | | | | | | | | _ | le. | |
|---|-------------------|--|--|--|---------------------|---|---|---------------------------------------|------------------|--|------------------|--------------------------------------|--------------|--|
| | | For State | ND#10 | State of M | - | | artment of <i>tificate of</i> | | and N | /lental Hy | | 2 11 | 2 | 2222 |
| | , | 1. Decedent's Name | e (First, Middle, L a | • | | , | | Death | | 2. Date of De | | | | 3. Time of Death |
| Physicia Medic | al | Gaston | | Ashbourne e street and number) | <u> </u> | Cro | | | (D - 1) | June | | | | 1450 м |
| Examin | | Holy C | cross H | | | | 4b. City, Town, Silv | ver S | or Death prin | ng | 40 | Mont | gon | ery |
| Funeral Director | | 5. Social Security No. 215-17- Usual Residence of | 5082 | Sex 7. Ag | e (In yrs. Ia 85 | ast birthday) Yrs. | If Under 1 Year Months Day | | 24 Hrs. Min. | 8. Date of Bi (Month, D 3 / 2 3 | rth ay, Year) | 27 g. | | lace (State or Foreign Naica |
| Maryland 28a-f show otified at | rector | 10a. State MD | 10b. County Prince | e George' | | y, Town or Lor Hyati | cation tsville | <u> </u> | | | | · | 10 | 0d. Inside City Limits |
| h with the ns 23a or 2 nust be no | Funeral Director | 10e. Street and Nun 6621 24 | | nue | | | 10f. Zip Code | | | | 109. C | itizen of Wha | t Coun | try? |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ρ | 11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed | ed 2 🔀 Married 4 🗌 Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates. | Ever in U.S No | | Was Decedent of f Yes, specify Cu | ban, Mexicar | n, Puerto | ecify Yes or No Rican, etc.) | - | 14. Race - A Black, V Specify: | | etc. |
| hin 72 houne. ne. than "nati | Completed | (Sperior (Sp | 15. Decedent's cify only highest g andary (0-12) | | 5+) | (Give life. D | dent's Usual Occ kind of work don O NOT use retire rpente: | during mos d) | t of work | ing | | Kind of Busin | | • |
| be filed wit sntal Hygie ked other c event, th | To Be C | 17. Father's Name (F | 1. | | | Ca | Грепте | 18. Moth | | e (First, Middle | , Maiden | Surname) | CI y | |
| 12 should alth and Me 27 is marl r traumati | | 19a. Informant's Na | me/Relationship (| Type, Print) | | 19b. Mailir 662 | ng Address (Stree 1 24th | | | | - | | , Zio C |)782 |
| Page 1 and nent of Hei ant: If item iry or othe | | 20a. Method of Disp 1 XBurial 2 | osition | Removal from State | | emetery, cren | sition (Name of matory or other p f Heave | ace) | | Date 3/2012 | | ocation - Cit | | wn, State oring, Md |
| permit. Departn Importa any injt | | 21. Signature of Fur | nera Service Liner | Unll | | | HNETEINPAde 241 Co | | | | | | | E,P.A. g,Md20910 |
| Physician/ Medical | | 23a. Part 1. Enter the desase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death PEAIS |
| Examiner | er | Sequentially list cor if any, leading to im | nditions, | b. Due to (or as | | | | | | | | | \downarrow | |
| icate be executed gliphysician and as the burial teges! | Examiner | cause. Enter Under Cause (Disease or i that initiated events resulting in death) L | lying injury | c. Due to (or as | | | | · · · · · · · · · · · · · · · · · · · | _ | | | | + | |
| ficate be e g physicia as the bur | dedical | 15.55144.5 | • | d | | | | | | | | | \perp | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu | Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown | nonths? | 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Feta | al death 3 | Ectopic pregna Other (specify) | ncy | | | | 23d. Date of Month | | ery Day Year |
| uires that t n signed b uld be detz | | | | | | | | | | | | | | e cause of death? |
| he law requite has beer bage 2 shou | Completed by | pneumor | | | | 24a. Was auto perf 1 \(\sum \) Yes | opsy ormed? | prior deat | to cor h? | osy findings available inpletion of cause of | | | | |
| ician: T sertifica ector, p | Be | 25. Was case referre | | Hospital: | | | | Place of Dea | th (Checi | | 2 23 11 | | | |
| ling Phys h. After this (funeral dii | ate: To | 27. Manner of Death | No 5 Pending Investigation | 1 XInpati 28a. Date of inju (Month, Da | ıry | 28b. Time of injury | nt 3 □ DOA 28c. Inj | 4 ∐ Nı | | ome 5 Res 28d. Describe | | | pecify) | |
| al or Attendests after deats I Director: | l Certificate: | 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide | eet, factory, office | | 1140 | 28f. Location (City or To | | | Rural | Route Number, | | | | |
| he Hospit in 24 hour ne Funer? pletely fill. | Medical | (Check 2 | Medical Exam | ysician: To the best of niner: On the basis of e rse Practitioner: To th | examination | n and/or invest | tigation, in my opi | nion, death o | ccurred at | t the time, date | and place | e, and due to | the cau | se(s) and manner stated |
| Vithi Vithi | | 29b. Signature and t | ittle of certifier | moni | | | | 3367 | | | | ate signed (M | | |
| | | Rajan | Shyams | completed cause of c undar M.I | 0. 9 | 801 G | eorgia | Ave | #117 | 7 Silv | er | Sprin | g,N | 4d 20902 |
| Stat Registra | | 31. Date filed (Month | n, Day, Year) 2 7 201 | 2 32. Registr | ar's Signa | far | N.S. | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | State | partment of Health and I ertificate of Death | | 2012 2222 | | | | |
|--------------------------|---|-------------------|---|---|--|---|--|--|--|--|
| | | | Registra MEND#20boerFH, 7/9/12; BWW, MoCo 1. Decedent's Name (First, Middle, Last) | ertificate of Death | Reg | 3, No. 2 | | | | |
| H | Physic /Medi | | Stephen Ding Chong | | June | 25, 2012 1:59A M | | | | |
| 2.00 | Exami | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | | |
| - 1 | | | 3634 Bel Pre Road #13 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda | Silver Spring | | Montgomery | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 68 Yrs. | Months Days Hours Min. | (Month, Day, Y | | | | | |
| | | | Usual Residence of Decedent | | DEC. 26,1 | 943 Trinidad&Tobago | | | | |
| | the Marylar 28a-f show | o. | 10a. State 10b. County 10c. City, Town or Maryland Montgomery Silver | | | 10d. Inside City Limits | | | | |
| | the N | Director | 10e. Street and Number | 10f. Zip Code | 100 | 1 ☐ Yes 2X No | | | | |
| | h with | | 3634 Bel Pre Road #13 | 20906 | | SA - | | | | |
| | ems : | Funeral | | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - American Indian, | | | | |
| 36 | s afte | by Fi | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No | 1 ☐ Yes 2 ☐ No Specify: | Trican, etc., | Black, White, etc. Specify: Black | | | | |
| 21215-0036 | be filed within 72 hours after death with the Maryland ntal Hygiene. 44 other than "natural", or items 23a or 28a-f show event, the Moteral Evariene must be notified at | ted | 15. Decedent's Education 16a. Dec | cedent's Usual Occupation | 16 | b. Kind of Business/Industry | | | | |
| 218 | within 7 iene. than "n | Completed | (Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+) | ve kind of work done during most of work . DO NOT use retired) | king | , | | | | |
| 121 | filed within Hygiene. Ither than " | | 12 Limo | usine Driver | | Transportation | | | | |
| Maryland | should be fi nd Mental H marked ot Imatic ever | Be | 17. Father's Name (First, Middle, Last) Albert Ding Chong | | e (First, Middle, Mai ry Toussa: | | | | | |
| aryl | | 2 | 19a, Informant's Name/Relationship (Type. Print) 19b. Ma | | and Number or Rural Route Number, City or Town, State, Zip Code) Road #13, Silver Spring, MD 20906 | | | | | |
| | 5 ± 0 F | | | Bel Pre Road #13, | Silver S | pring, MD 20906 | | | | |
| Baltimore, | Pages 1 and ment of Healt and title item 2 and to other any or other | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, ci | position (Name of ematory or other place) | Date 200 5,2012 | c. Location - City or Town, State | | | | |
| ΞÏ | 进生世世 . | | 4□Donation 5□Other (Specify) Fort Lin | coln Crematory UK | Brentwood, Maryland | | | | | |
| Ba | Depa Impo any l | | | 251mp1e^dribtrie Fu 1040 Rockville Pik | | | | | | |
| | c | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. | | | | | | | |
| 4 | Physician | H | Immediate Cause (Final disease or condition | Cancar | | Onset and Death | | | | |
| 1 | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | , dancer | | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | | | |
| | cuted and a | Examiner | Sequentially list conditions, if any, leading to immediate cause. Chart Underthing Cause (Disease or injury that initiated events | | | 7 | | | | |
| 90, | oe exe | EX | resulting in death) Last Due to (or as a consequence of): | | | | | | | |
| 68760, | ificate be executed g physician and is the buridifficacti | edical | d | | | | | | | |
| Box | | n/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 02d Date of delivery | | | | |
| Ö. | death | Physician/M | in the past 12 months? 1 Yes 2 No | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of delivery Month Day Year | | | | |
| P.O. | d by the | Phys | 9 Unknown 9 Unknown | | | | | | | |
| ds, | res t | þ | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | 23e. Did tobac | co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown | | | | |
| Cor | w requir s been s should | letec | | | _ | | | | | |
| Division of Vital Record | The law te has age 2 s | Completed | | | 24a. Was an autopsy performed | 24b. Were autopsy findings available prior to completion of cause of death? | | | | |
| ta | | Be C | 25. Was case referred to medical examiner? | 26. Place of Deat | 1 ☐ Yes 2 ☑ n (Check only one) | No 1 ☐ Yes 2 █ No | | | | |
| of o | Physic this or | | 1 ☐ Yes 2 【 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie | | me 5 🛚 Residence | e 6 ☐ Other (Specify) | | | | |
| 00 | Ing The Ing | tion | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation | Work? | 28d. Describe how in | njury occurred | | | | |
| /ISI | Attendir death. | fica | 3 Suicide 6 Could not be 28e Place of Injury - At home farm s | | 28f. Location (Stree | t and Number or Rural Route Number, | | | | |
| בֿ <u>:</u> | tal or rs afte al Dira | Certification: To | 4 ☐ Homicide determined building, etc. (Specify) | | City or Town, S. | tate) | | | | |
| | | | 29a. Certifier (Check only one) 1 | th occurred at the time, date and place, | and due to the caus | se(s) and manner as stated. | | | | |
| | o the | Medical | one) and manner stated. 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Day, Year) | | | | |
|) | 5 | | Douluamamam | MD035067 | | ne 26, 2012 | | | | |
| | | + | 30. Name and address of person who completed cause of death (Item 23a) (Type | | | | | | | |
| | | | Dr. D. Subramaniam 3800 Reservoir 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Road, NW Washin | gton DC 2 | 0007 | | | | |
| | Stat Registra | ٧ | 31. Date filed (Month, Day, Year) JUN 2 7 2012 32. Registrar's Signature | alis. | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - State Registrar | | State of | iviaryiand | | tificate of L | | and iv | ientai i | Tygier Reg. i | 21 | 012 | 22 | 223 |
|-------------------------------------|---|--------------|--|-------------------------------|---------------------------|--|-------------------|--|-------------------------|-----------------|---------------------------------------|-----------------------------|--------------------|----------------------------|---|---------------|
| ı | Physicia | | 1. Decedent's Name <i>(First,</i> Robert | | t) VL | Cefail | . Sr | _ | | | 2. Date of Month | Death | Day 2012 | Year | 3. Time of 5:51 | |
| - | Medic Examir | | 4a. Facility Name (if not ins | | | | , 0.0 | 4b. City, Town, or | Location o | f Death | June | | 4c. County | | [3.31 | <u>r "</u> |
| المصيب | | | Holy Cross H | • | | | | Silver S | | | | | Monte | gomer | y | |
| | Funeral Director | | 5. Social Security Number | 6. Se | | 7. Age (In yrs. last | birthday) | If Under 1 Year Months Days | If Under 2 Hours | 24 Hrs. Min. | Date of (Month) | Birth Day, Year | 7) | 9. Birthp Count | lace (State or | Foreign |
| _ | | | 016-22-3864 Usual Residence of Dece | | X M 2 □ F | 83 | Yrs. | | | | Jan. | 27, | 1929 | Mass | achuse | tts |
| | land shov d at | 후 | 10a. State 10b. 0 | County | | 10c. City, 1 | Town or Loc | ation | | | | | | 10 | 0d. Inside Cit | y Limits |
| | Mary 28a-f otifie | Director | | ntgom | ery | Silv | er Sp | ring | | | | | | | 1 🗆 Yes | 2 X No |
| | th the | | 10e. Street and Number | | | | | 10f. Zip Code | | | | - | Citizen of V | | • | |
| | ath wi | Funeral | 9727 Mt. Pis | gah Ro | | ent Ever in U.S. | 12.14 | 20903 | ia-ania Od- | i=0 /C=+ | if . Ven ev l | | ted S | | | |
| (0 | 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at | by Fi | 11. Marital Status 1 Never Married 2 | X Married | Armed Force | es? | lis. v | Vas Decedent of Hi Yes, specify Cuba | n, Mexican, | Puerto F | Rican, etc.) | VO- | | e - America k, White, e | | |
| 21215-0036 | ırs aft ıral", I Exaı | edk | 3 🗆 Widowed 4 🗆 Di | | If Yes, Give | es Korea | 1 | ☐ Yes 2 X No | Specify: | | | | Specify: | Whit | te | |
| 5-0 | 2 hou "natu edical | plet | | ecedent's Ed y highest gra | ducation de completed) | | | ent's Usual Occup | | of workir | na | | Kind of Bu | | | |
| 121 | within 7 giene. er than , the Me | Completed | Elementary/Secondary | | College (1-4 | l or 5+) | life. DC | NOT use retired) | annig meet | | 9 | ^ | _ | _ | ecurit | y |
| | filed wi al Hygie d other | Be | 17. Father's Name (First, M | iddle. Last) | | | Стур | wwyrsi | 18 Mothe | r'e Name | /First Mid | de Maide | an Surname | genc | <u>y</u> | |
| Maryland | be fil lental rked ic ev | ပ | G. Edgar | | fail | | | | Elna | | | oulin | | 7 | | |
| ary | hould and M s mai | 8 | 19a. Informant's Name/Re | | | | 19b. Mailin | g Address (Street a | | - | | | | tate, Zip C | ode) | |
| | and 2 s Health a em 27 i ther tra | | Dolores Cefa | il, i | spouse | | | Mt. Pisgo | | | | | | | | 903 |
| ore | e 1 ar of He If iten | | 20a. Method of Disposition 1 Durial 2 X Crer | | Removal from S | 20b. Plac | e of Dispos | sition (Name of natory or other plac | | | ate | | Location - | | | |
| Ë | Page tment o tant: If jury or | ,, | 4 Donation 5 C | ther (Specif | Tiernovai iroin s | Ft. | Linco | en Crema | tory | | | | | | | |
| Baltimore, | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Se | pice Liceris | - fri | 40070 |) 22. 11 | Name and Addres | ss of Facility Hamps | lines | -Rina Ave. | ıldi . Si | Funer Ever | ial Hi Sprin | ome, I | nc. 20904 |
| | of . | | 23a. Part 1. Enter the disc shock, or heart failure | ase, or comp | olications that can | used the death. [| | | | | | | | | Approximate | |
| -) | Physician/ | 0 0 | Immediate Cause (Final disease or condition | J | | IONARY EI | MBOLT. | SM | | | | | | 4 | Interval Betw Onset and D minu | |
| | Medical Examiner | | resulting in death) | | Due to (or | r as a consequen | ce of): | | | | | | | 1 | - III-CILOC | - |
| | | er | Sequentially list conditions | | D | (BOEMBOL | | SEASE | | | | | | | | |
| | po tig | Examiner | cause. Enter Underlying Cause (Disease or injury | | Due to (or | as a consequen | ce oij: | | | | | | | | | |
| | xecut a and | Еха | that initiated events resulting in death) Last | | C. Due to (or | r as a consequen | ce of): | | | | | | | | | |
| 0 | icate be executed physician and is the bural trans | edical | | L | d | | | | | | | | | | | |
| 8760 | tificate ng phy as th | | IF FEMALE: | | | | | | | | | | | | | |
| 89 × | tendii tendii or use | Physician/M | 23b. Was decedent pregna in the past 12 months | 16 | 1 🔲 Live Bi | ome of pregnancy irth 2 Fetal d | eath 3 🗌 | Ectopic pregnanc | у | | | 23 | | e of delive | , | |
| å | e dear the at hed fo | ysic | 1 Yes 2 No | | 4 ☐ Pregna 9 ☐ Unkno | ant at time of dea wn | th 5 ∐ | Other (specify) | | | | | Mor | nth I | Day Ye | ear |
| Division of Vital Records, P.O. Box | ss that the death certificing igned by the attending be detached for use as | | Part II. Other significant c | onditions co | ntributing to dea | ath but not resulti | ng in the ur | nderlying cause giv | en in Part I. | | 23e. Di | d tobacco | use contri | ibute to the | e cause of de | ath? |
| S, F | ires the signer of the signer | d by | DIABETES M | | | | | | | | 1 | ☐ Yes | 2 🗌 No | 3 Prob | ably 4 🗶 U | nknown |
| ord | required shou | lete | | | | | | | | | 24a. W | as an | 24b. V | Vere autop | sy findings av | ailable |
| Sec. | he lav te has age 2 | Completed | | | | | | | | | au | itopsy erformed? es 2 | | leath? | pletion of ca | use of |
| a F | an: Tl rtifical stor, p | Be C | 25. Was case referred to me | edical | | | | 26. Pla | ace of Death | ı (Check | | es 2 🔼 | No 1 | ☐ Yes | 2 🗆 No | |
| Ĭ | nysici nis cer I direc | To E | examiner? 1 Yes 2 X No | F | Hospital: 1 🔲 In | patient 2 XER | /Outpatient | 3 DOA Othe | er: 4 🗌 Nun | sing Hon | ne 5 🗆 R | esidence | 6 🗌 Othe | r (Specify) | | |
| o | ding Physician: The law h. After this certificate has funeral director, page 2 | | 27. Manner of Death 1 X Natural 5 | Pending | 28a. Date of (Month, | injury 28 Day, Year) | b. Time of injury | 28c. Injury work' | | 2 | 8d. Describ | e how inju | ury occurre | ed | | |
| jo | ttend death tor: A | Certificate: | 2 Accident | nvestigation Could not be | 20 81 | | | M 1 | Yes 2 1 | - | | | | | | |
| Σ | or Al after Direc | | 4 Homicide | determined | 28e. Place of building | f Injury - At home _I , etc. <i>(Specify)</i> | , farm, stre | et, factory, office | | 2 | | n (Street a Town, Sta | | r or Rural I | Route Numbe | r, |
| | To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | ledical | 29a. Certifier 1 X Cer | tifying Phys | ician: To the bes | st of my knowledd | ge, death o | ccurred at the time | , date and n | olace, and | d due to the | e cause(s) | and mann | er as state | d. | |
| | he Hc in 24 l he Ful pleter | Med | (Check 2 \sqcup Me | dical Examir | ner: On the basis | of examination ar | nd/or investi | gation, in my opinio death occurred at th | n, death occ | curred at t | he time, da | te and plac | ce, and due | to the caus | se(s) and man | ner stated. |
| | | _ | 29b. Signature and title of o | | 2 / | | | 29c. License | | | | | ate signed | | | |
| | 441 | | tank | 15,6 | Sell | - ms | | D3511 | 12 | | | Ju | ne 23 | , 20 | 12 | |
| | | | 30. Name and address of p | | | | | | | Ciar | | III) e | 0010 | | | |
| | Stat | | Paul B. Bak 31. Date filed (Month, Day, | (ear) | | | | | uver | . spr | rny, | MV Z | U71U | | | |
| | Stat Registra | | JUN 2' | | Sen | jistrar's Signature | park | 1 | | | | | | | | |

| | | | For State O | f Maryland / Depa | | | Mental Hy | giene | | |
|---------------------------------|--|-------------------------|---|---|--|----------------------------|-----------------------------------|------------------------------|--------------------------------|------------------------------|
| | | | Registrar | Cei | tificate of L | Death | | Reg. No. 2 | 112 | 22224 |
| | Physicia Medi | | 1. Decedent's Name (First, Middle, Last) Maria Ines Castillo | | | | 2. Date of Deadler June | _ | 1 ^Y 2 ^{ar} | 3. Time of Death 10:58 aM |
| 100 | Examir | | 4a. Facility Name (if not institution, give street and num | , | | Location of Death | 1 | 4c. County | | |
| magas of | Funeral | | Washington Adventist Hos 5. Social Security Number 6. Sex | Spital 7. Age (In yrs. last birthday) | Takoma If Under 1 Year | Park If Under 24 Hrs. | I o Data of Dis | | gomery | |
| | Funeral Director | | 216-33-0250 1 M 2 M F | 71 _{Yrs.} | Months Days | Hours Min. | 8. Date of Birt (Month, Day | v, Year) | 9. Birthplac Country, | ce (State or Foreign) |
| | _ MC | | Usual Residence of Decedent | | | | March 5 | , 1941 | E1 9 | Salvador |
| | yland -f sho ed at | cto | 10a. State 10b. County | 10c. City, Town or Lo | cation | | | | 10d | I. Inside City Limits |
| | e Mau r 28a notifi | Jie. | MD Montgomery 10e. Street and Number | Silve | r Spring | | | | | 1 🗌 Yes 2 🔀 No |
| | ith th | a | 8735 Carroll Avenue | | 10f. Zip Code 20910 | | | 10g. Citizen of W | /hat Country | 1? |
| | ems: | Funeral Director | | dent Ever in U.S. 13. V | Vas Decedent of Hi | spanic Origin? (Sr | ecify Yes or No- | | - American | Indian |
| 21215-0036 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 🛣 Widowed 4 ☐ Divorced | ces? 1 2 🔀 No | Yes, specify Cubar | n, Mexican, Puerto | Rican, etc.) | Black | k, White, etc White | |
| 15- | 72 ho 1 "nat ledica | l ble | 15. Decedent's Education (Specify only highest grade completed) | (Give I | lent's Usual Occupa kind of work done d | ation uning most of wor | king | 16b. Kind of Bu | siness/Indus | stry |
| 12 | ithin ene. r thar | Completed | Elementary/Secondary (0-12) College (1- | 4 01 5+) | naker | | | Own H | Iome | |
| b | iled w I Hygi othe /ent, | Be | 17. Father's Name (First, Middle, Last) | IIOINC | maker | 18. Mother's Nan | ne (First, Middle. | Maiden Surname) | | |
| /lar | d be f Menta arked artic ev | 은 | Unknown Castillo | | | Maria | Ines Ca | stillo | | |
| Maryland | shoul and I s ma | - 6 | 19a. Informant's Name/Relationship (Type, Print) | | g Address (Street a | | | | | |
| , S | and 2 fealth sm 27 sher to | | Roberto Castillo/Son 20a. Method of Disposition | | 4 Bond St | reet, S | llver Sp | ring, MD | 2090 | 2 |
| Baltimore, | permit. Page 1 a Department of I Important: If ite any injury or ot | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) | State 20b. Place of Disposers Gate of Cem | Jur | Date 1e 28, 1012 | 20c. Location - 0 Silver S | • | | |
| Balt | permit. Depart Import any inj | | 21. Signature of Preral Service License | | Home Inc. Iver Spring, MD 20901 | | | | | |
| | | | 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac | aused the death. Do not ente | r the mode of dying | , such as cardiac | or respiratory arr | est, | A | pproximate terval Between |
| 112 | Physician/ | 87.3 | Immediate Cause (Final disease or condition Sepsi | | | | | | | nset and Death |
| | Medical Examiner | | reculting in death) | r as a consequence of): | | | | | | |
| | | er | | c Shock | | | | | | |
| | Usit ed | Examiner | cause. Enter Underlying | rasa consequence of): Respiratory | Fat lura | | | | - 4 | |
| | xecut al-tra | Еха | that initiated events C. | r as a consequence of): | railule | | | | + | - |
| 0 | icate be executed in physician and its the bural-transit | edical | d | | | | | | | |
| 876 | tificate ng phy as th | Med | IF FEMALE: | | | | | | | |
| Box 68760 | tendir tendir or use | ian/ | 23b. Was decedent pregnant 23c. If yes, outc | ome of pregnancy irth 2 🗆 Fetal death 3 🗀 | Ectopic pregnancy | / | | 23d. Date | of delivery | |
| Bo | requires that the death certific been signed by the attending should be detached for use as | Physician/M | 1 ☐ Yes 2 ☐ No 4 ☐ Pregn 9 ☐ Unknown 9 ☐ Unknown | | Other (specify) | | | Mont | th Da | y Year |
| Division of Vital Records, P.O. | at the detac | | Part II. Other significant conditions contributing to de | ath but not resulting in the ur | nderlying cause give | en in Part I. | 23e. Did to | bacco use contrib | oute to the c | ause of death? |
| S, F | ires th | d by | | | | | | | | ly 4 🗆 Unknown |
| ord | v requ | Completed | | | | | 24a. Was a | | | findings available |
| Sec. | sician; The law is certificate has bilirector, page 2 s | mo | | | . ,, | | autop: perfor | sy pr med? de | eath? | etion of cause of |
| a | ian: T rtifica ctor, p | | 25. Was case referred to medical examiner? | | 26. Pla | ce of Death (Chec | 1 ☐ Yes k only one) | 24 Noj 1 | Yes 2 | □ No |
| ξ | hysic nis ce il direc | 일 | Hospital: | npatient 2 ER/Outpatient | 3 DOA Other | 4 Nursing Ho | ome 5 Reside | ence 6 🗆 Other | (Specify) | |
| 0 | ing P | ate: | 27. Manner of Death 28a. Date o Natural 5 ☐ Pending (Month) | finjury 28b. Time of injury | 28c. Injury work? | | 28d. Describe ho | w injury occurred | 1 | |
| ior | ttend death stor: / the f | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be | | | res 2 □ No | | | | |
| Nie | l or A after Direction by | Cer | 4 Homicide determined 28e. Place of building | f tnjury - At home, farm, stre g, etc. (Spec <i>ify)</i> | et, factory, office | | 28f. Location (St City or Town | reet and Number n, State) | or Rural Ro | ute Number, |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director, there this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burgal-trans. | Medical | 29a. Certifier 1 Certifying Physician: To the be 2 Medical Examiner: On the basis | st of my knowledge, death or | ocurred at the time, | date and place, a | nd due to the cau | use(s) and manner | r as stated. | |
| , | the hithin 2 the Formplet | | only one) 3 Certifying Nurse Practitioner: 29b. Signature and title of certifier | To the best of my knowledge, | death occurred at the | e time, date and pl | ace, and due to th | e cause(s) and ma | nner as state | ed. |
| | 3 | | ignature and the certifier | | 29c. License | 160100 | | 9d. Date signed (| Month, Day, | 7 |
| | | 1 | 30. Name and address of person who completed cause | of death (Item 23a) (Type, Pr | | tmin A | 10 | 06-2 Ay | npn | |
| | | | 851 Universe | ISTUD EM | T | Silversh | of Mo | 49.3 | | |
| | Stat Registra | · | 31. Date filed (Month, Day, Year) JUN 27 2012 | of death (Item 23a) (Type, Pr | 20 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 8:24 M Physician/ Month 910 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death topkins Hospita Baltimor TMOVE Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 172-30-2761 Months **Director** 1 🗷 M 2 🗆 F 2-7-1936 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location be notified at 10d. Inside City Limits Director BEDFORD HYNDMAN 1 🗌 Yes 2 🔀 No 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral HYNDMAN ROAD must ! USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc þ 1 ✓ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. Specify: White "natural", 3 Widowed 4 Divorced If Yes, Give Year or Dates, 1956-59 Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 16PERATOR TRUCKING OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ COBLEY MABEL other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15545 Page 1 and 2 shament of Health a lant: If item 27 is HYNDMAN RD POBOX 495 HYNDMAN EVELYN S. CORLEY Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of Important: If it any injury or conce. 1 🖪 Burial 2 🗌 Cremation 3 🖬 Removal from State 6-30-12 HYNDMAN OMPS CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility HARVEY H. ZEIELER HYNDMAN 13545 23a. Part I. Enter the disease, or complications shock, or heart failure. List only one caus. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ach line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day the U*n*known ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 1 🗌 Yes ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 7. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: After (Month, Day, Year) 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) Concell Cla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

1800

32. Registrar's Signature

Orleans St Baltimore, MD. 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mønth Physician/ Clark Elaine Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Western MD Regional Med ctr If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Director 55 1 🗆 M 2 💢 F 234-98-9951 Aug 20,1956 MD Usual Residence of Dece 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wiley Ford 1 Tyes 2 H No WV Mineral 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 26767 USA RR1 box 73 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2XXMarried 1 Yes 2 No If Yes, Give X White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) physical therapy assistant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked မ Elizabeth (Small) Mary Myr1 Thomas Zimmers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RR1 Box 73, Wiley Ford, WV 26767 Michael Clark / husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/26/12 Cumberland, MD Sunset Memorial Park Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, 21. Signatur 404 Decatur Street, Cumberland, MD 21502 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atter in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 NO ၉ 1 Impatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

5 nds

Registrar

DHMH 17 Rev 06-2011

29a. Certifier

only one) 29b. Signature and

Blanche Mavromatis,

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

12502 Willowbrook Rd., Suite 300, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hooth B Lovelet McDaniel Custis 11:50 A M Lovette Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death omico If Under 24 Hrs. 7. Age (In yrs. last birthday Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 64 213-44-0596 Director 1 🛛 M 2 🗆 F 04/01/1948 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumetic event, the Medical Examiner must be notified et once. 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 400 Nomreh Road 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married δ $L_0 Ve He CuS+J$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) University of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Director of Public Safety Eastern Shore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Corbin Ward Iva Finnison Custis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Nomreh Road, Salisbury, Maryland 21804 Diane L. Custis/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/23/2012 Pocomoke, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Sinai Bapt. Cem. 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL CARCINDMA Physician/ MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2/ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Funerel Director: After this certificate has I completely filled in by the funeral director, page 2 is autopsy 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 31 No ျှ HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a d title of certifier D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 150 Year 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ June 15, John W. Conway Jr. 3:34 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 1207 Riverside Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours **Director** 1 XM 2 🗆 F 118-03-0202 Pennsylvania 12|28|1920 91 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** any injury or other traumatic event, the Medical Examiner must be notified 1 Tes 2 No Maryland | Wicomico Salisbury 10f. Zip Code ò 10g. Citizen of What Country? items 23a 21801 USA 1207 Riverside Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No Army
If Yes, Give
Year or Dates Air Crop. ò Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 Kidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roofing and Sheet Meta Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John W. Conway Irene McBride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 1207 Riverside Dr., Salisbury, Maryland 21801 Bernard Conway son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 06 18 2012 Salisbury, Maryland Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final PBRTENSION Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 24a Was an autopsy performed Yes 2 page 2 s has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\to\) Nursing Home 5 \(\textstyle{\textstyle{1}}\) Residence 6 \(\to\) Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 06 7201 12058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SACISTA WAN 6 HUMON 130 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

HIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Arlene Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Month Day, Year 1938 Country Maryland 218-38-0662 73 Director 1 🗆 M 2 💢 F Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Lonaconing Allegany Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21539 USA 12 East Florida Way within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. or, 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည James Jones Mary Catherine Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Cook - Husband 12 East Florida Way, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ry, crematory or other place)
Mt. View Cemetery 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Moscow Mills, Maryland July 09, 2012 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. any in once. 8 East Main Street Lonaconing, MD 21539 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between) Set and Death Physician/ disease or condition Medical resulting in death) nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or sels corresquence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending physical for use as the k IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death the bed signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy 1 Ves 2 certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ ER/Outpatient 3 DOA Inpatient 2 this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After etely filled in by the funer injury 5 Pending Natural 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F
complet 3 🗆 only one) certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howbroad Road, Cumberland

Registrar
DHMH 17 Rev 06-2011

State

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:40 p 2. Date of Death Day 2012 Physician/ June R. Dresch 23. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenton Assistant Living Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. oct 2, 1919 New Jersey 155-12-2024 92 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Frederick Maryland Frederick 1 Yes 2X CNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21702 8338 Jordan Valley Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked of any injury or other traumatic eve 0 Irene Murray John Dobbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Greene - daughter 8338 Jordan Valley Way, Frederick, Maryland 21702 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Saint Bernard Cemetery 6-28-2012 Bridgewater, New Jersey 4 Donation 5 Other (Specify) any in 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Jennenting disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of): nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last executed Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail Com.
Pregnant at time of death ☐ Ectopic pregnancy atten in the past 12 month ò Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 1 70 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate funeral director, pag 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be ASSISTED Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signatu ke and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Shah

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31. Date filed (Month, Day, Year)

Thomas

32. Registrar's Signature

MD

Frederick

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Vital

Division of

Registrar

JUN 26 2012 DHMH 17 Rev 06-2011

Abdulsalam, M.D. 1500 Forest Glen Rd. Sliver Spring, MD 2090

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Davidson I. 9:40P Julia 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Fairfield Nursing and Rehab Center Crownsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** West virginia 234-80-3988 80 **Director** 1 □ M 2 🛣 F 7/2/1931 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🗶 No Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 1454 Fairfield Loop 21032 or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White and Mental Hygiene. 3 🗌 Widowed 4 🗌 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Davidson Della Dayton Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2052 Tilghman Dr. Crofton, MD 21114 Anna Phillips/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Ebenezer Cemetery 1 Burial 2 Cremation 3 X Removal from State Romney, West Virginia 6/15/2012 4 ☐ Dogation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has autopsy page perform death? 1 Yes 2 W 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 2 **X** No ဂ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A bletely filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu ho completed cause of death (Item 23a) (Type, Print) Sw State Registrar

| | | Please | Type or Prin | | | | | | | | | _ | ible. | |
|--|-------------------|--|--|---------------------------------|---------------------------------|---|-----------------------------------|---------------------|-----------------------|--|--------------|---------------------|--------------------------------|--|
| | | For State | State of Ma | ryland / | | artment tificate | | | and N | 1ental Hy | | 21 | 111 | 2 2223 |
| Physicia | -/ | Registrar 1. Decedent's Name (First, Middle, Last | , | 1.0 | | incare | 0, 2 | Cutii | | 2. Date of De | Reg. eath | | V 1 (| 3. Time of Death |
| Medic | al | Clarence 4a. Facility Name (if not institution, give | Herman Du | dley, | Sr. | 4h City To | | Location | of Dooth | June 2 | 3, | 2012 | Year | 1314 M |
| Examin | er | Holy Cross Hospit | | | | 4b. City, To Si. | 1ve: | r Spr | ing | | | 4c. County Montg | omer | у |
| Funeral Director | | 5. Social Security Number 579-14-2697 Usual Residence of Decedent | 7. Age | (In yrs. last bi | irthday) Yrs. | If Under 1 Months | Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da 7 / 23 / 1 | | ar) | 9. Birth Cou Nort | hplace (State or Foreign intry) Carolina |
| Maryland 28a-f shov otified at | irector | DC 10b. County | | 10c. City, Tov Wa | wn or Loc ashir | ation ngton | | | | | | | | 10d. Inside City Limits 1 ★ Yes 2 □ No |
| th with the ns 23a or must be n | Funeral Director | 10e. Street and Number 2011 4th Street, | | | | 10f, Zip C | | 2000 | | | | Citizen of V | | untry? |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Even Arroyed Forces? 1 Arroyed Forces? 1 Yes 2 No of Yes, Give Year or Dates. | ^{er in} 1943 ° 1946 | | Vas Deceder Yes, specify ☐ Yes 2 | / Cubar | n, Mexican | gin? (Spe , Puerto | cify Yes or No- Rican, etc.) | | | k, White | ican Indian, , etc. _ack |
| within 72 hou giene. er than "nat , the Medic a | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade | | | (Give k | ent's Usual (ind of work of NOT use re Ce Roo | done di etired) | uning most | of work | ng | | reau nd Pri | | ndustry Ingraving ng |
| ld be filed Mental Hy arked oth atic event | To Be | 17. Father's Name (First, Middle, Last) Jacob Astor Dudle | <u> </u> | | | | | 18. Mothe | er's Nam | e (First, Middle, Appie | | | e) | |
| nd 2 shoul lealth and m 27 is m | | 19a. Informant's Name/Relationship (Ty) Duane Dudley (Son | | | | | | | | Route Number Bowie | | | | ^{Code)} 20716 |
| Page 1 ament of Hament of Hament if ite | | 20a. Method of Disposition 1 | | cemet | ery, crem | | e <i>r pl</i> ace rem a | atory | 6/2 | | A1 | | ria, | Virginia |
| permit Depart Impor any in | | 21. Signature of Funeral Service Licens | A Med 12 | لحما | | | | | | rshall- .W. Was | | | | al Home C. 20011 |
| Physician/ | | 23a Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition | lications that caused the cause on each line. Respira | | not ente | r the mode o | - | | | | | <u> </u> | | Approximate Interval Between Onset and Death |
| Medical Examiner | J. | resulting in death) Sequentially list conditions, | Due to (or as a c | | , | | | | | | | | | |
| executed an and in all the state of the stat | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a control of the contr | nia | | | | | | | | | _ | |
| tificate be exe | | Country in death, East | | Sonsoquence | . 0.17. | | | | | | | | | |
| or Attending Physician; The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the bu | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown | ☐ Fetal dea | | Ectopic pre Other (spec | | / | | | | 23d. Dai | te of deli | very Day Year |
| v requires that the bear signed by should be detail | by | Part II. Other significant conditions co Acute Renal Fail | | not resulting | in the ur | nderlying cau | use give | en in Part I | | | | | | the cause of death? |
| The law requate has been page 2 shou | Completed | | | | | | | | | 24a. Was auto perfo | psy ormed | 1? | orior to co death? | opsy findings available ompletion of cause of |
| i cian: The certificate rector, pag | Be | 25. Was case referred to medical examiner? | lospital: | | | | Othe | ce of Deat | h (Check | | | 1101 | | |
| ding Phys h. After this funeral di | sate: To | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of injury (Month, Day, | 28b. | Outpatient Time of injury | | . Injury work? | 4 <u>U</u> Nu at | | me 5 Resi 28d. Describe | | | | fy) |
| Hospital or Attendii 24 hours after death. Funeral Director: Al | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (| | farm, stre | | | 103 2 🗀 | IVO | 28f. Location (City or Tox | | | er or Rura | al Route Number, |
| To the Hospital of within 24 hours at To the Funeral Decorporate filled in Scorporate filled in the second | Medical | (Check 2 Medical Examir | ician: To the best of moner: On the basis of exame Practitioner: To the basis | mination and | or investi | gation, in my | opinior | n, death oc | curred at | the time, date a | and pl | ace, and due | to the ca | ause(s) and manner stated. |
| To the within | | 29b. Signature and title of certifier | n.B. | | _ | 29c. L | | number | | | 29d. | Date signed ne 23 | (Month, | Day, Year) |
| | | 30. Name and address of person who co Jonathan M. Duran | mpleted cause of dea 1500 | th (Item 23a) Fores | (Type, Pr | rint) en Roa | ad S | Silve | r Sp | ring, | Mar | yland | 209 | 10 |
| Stat Registra | | 31. Date filed (Month, Day, Year) JUN 27 201 | 32 Registrar's | s Signature | for | Ked. | | | | | | | | |

| | | | 101 | nent of Health and Mental Hygiene |
|----------------|--|------------------|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | cate of Death Reg. No. 2 U 2 2 2 3 4 2. Date of Death 3. Time of Death |
| | Physicia | | Susan Sprague Davis | June 16, 2012 Year 5:05 P M _ |
| | Medic Examin | | 4a. Facility Name (if not institution, give street and number) 4b. | City, Town, or Location of Death ethesda 4c, County of Death Montgomery |
| | Funeral | | 015 00 7116 | Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign this Days Hours Min. (Month, Day, Year) Country) |
| | Director | | Usual Residence of Decedent | 05/19/1928 Pennsylvania |
| | and show | or | 10a. State 10b. County 10c. City, Town or Location | |
| | Maryla 28a-f | rect | Maryland Montgomery Chevy Chase | 1 ⅓ Yes 2 ☐ No |
| | with the s 23a or ust be n | Funeral Director | 10e. Street and Number 5555 Friendship Blvd. Apt. 527 | of. Zip Code 10g. Citizen of What Country? 20815 United States |
| 036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | Armed Forces? If Yes | Decedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White |
| 21215-0036 | in 72 hou e. han "natu s Medical | Completed | (Specify only highest grade completed) (Give kind | Usual Occupation of work done during most of working IT use retired) 16b. Kind of Business/Industry |
| 7 | d with lygien ther tl nt, the | Be C | Homemak 17. Father's Name (First, Middle, Last) | er Own Home 18. Mother's Name (First, Middle, Maiden Surname) |
| anc | be file ental h ked o | To E | Rathburn Sprague | Marion Zimmerman |
| Maryland | 2 should th and M 27 is mar traumati | 5 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac 2006 Hi | dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) ntwood Drive Gambrills, MD 21054 |
| ē, | f Heall item 2 other | | WIIIIam Davis Jr. / Son 20a. Method of Disposition 20b. Place of Disposition | (Name of Date 20c. Location - City or Town, State |
| Ë | Page nent o ant: If ary or | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | |
| Baltimore, | permit. Departn Importa any inju | | 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ne and Address of Facility Joseph Gawler's Sons LLC O Wisconsin Ave. NW Washington, DC 20016 |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. | Interval Between |
| | Physician | i a | Immediate Cause (Final disease or condition as Pulmonary Embolism | Onset and Death |
| | Medical Examiner | | Due to (or as a consequence of): Atrial Fibrillatio: | |
| | ALC: | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to or as a consequence of): | |
| | nd nd | Examiner | Cause (Disease or injury that initiated events c. | |
| | e be executed ysician and ne bunation | al E | resulting in death) Last Due to (or as a consequence of): | |
| 9 | physic | edical | d | |
| Box 68/6 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bundary. | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ Otl | opic pregnancy 23d. Date of delivery Horth Day Year |
| , r. | law requires that the nas been signed by the e 2 should be detach | ρ | Part II. Other significant conditions contributing to death but not resulting in the under | lying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 🗶 No 3 □ Probably 4 □ Unknown |
| rds | requir been s should | etec | | 24a. Was an 24b. Were autopsy findings available |
| Vital Records, | The law ate has page 2 | Completed | | autopsy prior to completion of cause of death? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No |
| ta | ysician: is certific director, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 | 26. Place of Death (Check only one) |
| | g Phys er this eral di | e: To | 27. Manner of Death 28a. Date of injury 28b. Time of | 28c. Injury at 28d. Describe how injury occurred |
| ou | ath. r: Afte | icat | 2 Accident | M |
| Division of | al or Atte s after de I Directo ed in by th | Certificate: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify) | actory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| _ | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | (Check 2 Medical Examiner: On the basis of examination and/or investigation | rred at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. th occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| | | 2 | 29b. Signature and title of seatifier | 29c. License number 29d. Date signed (Month, Day, Year) |
| | 5 | | Thorn M-D | D30132 June 20, 2012 |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rita Chosh MD 14812 Physicians Lane | |
| į | Sta Registra | | 31. Date file (Month, Day, Year) JUN 27 2012 A. Registrar's Signature | |
| | . logiotii | | DOIL MI FALL DOIL | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 25 per OCME G929 //13/12 dk
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 14:20 PM Physician/ Dupski 2019 Rosemary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balti 00 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 217-12-6335 87 Director 1 □ M 2 🕱 F Maryland July 26,1924 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director 1 🗌 Yes 2 🙀 No Ellicott City Maryland | Howard 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21042 9071 Dunloggin Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married and 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Company Telephone Supervisor 12 other Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Minnie C. Marsiglia Frank Serio 1 and 2 should be of Health and Me Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3627 Grosvenor Drive; Ellicott City, MD 21042 Louis Dupski Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1

■ Burial 2

□ Cremation 3

□ Removal from State Crestlawn Mem. Gardens 7-2-2012 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a cause. Enter Underlying Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical the death certificate be use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Box in the past 12 month Month Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. that 1 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Records, Completed should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 20 No autopsy page 2 Vital Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: or Attending 1 / atural 5 Pending Division 2 Accident 3 Suicide Investigation within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse practitioner: To be easily in the cause of the caus (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinore 4D 2122 4300 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Denve B. farke HMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) $\mathbf{July}^{\mathsf{Month}}$ Physician/ 2012 12:00 PM Raymond Martin Eagan, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral Director** 214-60-7478 1 X M 2 □ F 60 04/04/1952 Washington, D.C. Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Dunkirk Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20754 3395 Old Jones Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner med Forces?
Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Printing 12 Printer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ethel Marie Newheiser Raymond Martin Eagan, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20754 Kathryn M. Landon/Sister 3395 Old JOnes Rd., Dunkirk, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 07/10/2012 Cheltenham, MD Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Aspiration meumonia disease or condition Medical resulting in death) Examiner VIHIDLE Scienosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Edema 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an tailune autopsy performed? Yes 2 SN Micen 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 🔀 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of D-50653 2000 0 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 851 State 0 5 201 Registrar

12-05033 Jose Victor Estrada

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend # State of Maryland / Department of Health and Mental Hygiene

2012 22237

| | | | - For State | | icate of | | | | Reg. N | Z U ! | |
|---|--|----------------|--|---|--------------------------------|------------------------------------|-----------------------------------|--|------------------------|--------------------------------|--------------------------------------|
| Phys | sicia | | egistrar I. Decedent's Name (First, Middle,Last) | | | | | 2. Date of D | Day | y Year | 3. Time of Death |
| ledical Ex | amii | | Jose Victor Estrada | | | | | July 5, 2 | 2012 | 4c. County of Death | 0846 hrs |
| 1 | | | 4a. Facility Name (if not institution, give street and number 6309 Somerset Road |) | 4 | c. City, Town, o Riverdale | r Location of | Death | ľ | Prince George | |
| Euro | 1 | | | ge (In yrs. last l | birthday) | If Under 1 Ye | ar If Under | 24Hrs. 8. Date of | Birth(MI | M/DD/YYYY) 9. Bir | thplace (Ştate or |
| Fune Direc | | | 213-61-2010 1 M 2 F | 45 | Yrs. | Months Da | _ | 1.00 | | Foreig | gn El ^(untry) Salvado: |
| î | Any | ŀ | 10a. State 10b. County | 10c. City, To | wn or Locatio | n | | | | | 10d. Inside City Limits |
|) | E | ᅵ | MD Prince Georges | Нуа | ttsvi | lle | | | | | 1 X Yes 2 No |
| Maryla | or 28a-f show fied at once, | Director | I0e. Street and Number | | | 10f. Zip Code | | | | Citizen of What Cou | |
| 215-0036 be filed within 72 hours after death with the Maryland mat Bygiene. | 23a or 28a-f sho notified at once. | | 6824 Riggs Road | | | 2078 | | | | l Salvad | |
| th with | t be n | Funeral | 11, Marital Status 1 X Never Married 2 Married Armed Forces | ? | 13. Was | Decedent of H s, specify Cuba | lispanic Origir an, Mexican, F | n? (Specify Yes or Puerto Rican, etc.) | No- | 14. Race - Amer White, etc. | ican Indian, Black, |
| er dea | , or i | | 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year | X No | 1[X] | Yes 2 N | o specify: | Salvado | ran | Specify: Whi | ite |
| ars aft | tural mine | à | 15. Decedent's Education (Specify only highest grade co | mpleted) 16 | Sa. Decedent | s Usual Occup | ation (Give ki | nd of work done | | . Kind of Business/ | Industry |
| 72 hoi | al Ex | ee | Elementary/Secondary (0-12) College (1-4 or | | | st of working lif | e. DO NOTu | se retired) | | | |
| vithin ene. | Medic tha | Completed | 12 | | Labor | er | I 75 Mallanda | Name (First, Middl | | Moving (| Company |
| 21215-0036 uld be filed within 7 Mental Hygiene. | narked other than "natural", event, the Medical Examiner | | 17. Father's Name (First, Middle, Last) Benancie Alberte Un | known | | | 1 | | | | Estrada |
| 2121 ould be fi | cven | To Be | 19a. Informant's Name/Relationship (Type, Print) | | 19b. Mailing | Address (Stre | | | | City or Town, State | |
| C of Fig. | 27 is numblic | -1 | Ana Estrada-sister | 1 | 12035 | Veir | s Mil | l Rd. A | pt : | 301 Sil | ver Spring |
| e, M 1 and 2 Health | t: If item 27 is no other traumatic | ı | 20a, Method of Disposition | I | ce of Disposit | ion (Name of c | emetery, | Date | 20 | c. Location - City or | Town, State |
| = 8 4 F | r of b | -1 | 1 XBurial 2 Cremation 3 Removal from S 4 Donation 5 Other Specify: | late | ily C | emeter | | | | :l Salva | |
| Baltimore, permit. Pages 1 an Department of Hea | Important: injury or oth | ı | 21. Signature of Funeral Service Licensee | | | | | | | n Funera | |
| | _ | _ | Wawda C. Balon CC. 23a. Part I. Enter the disease, or complications that cause | 0361 | 34 | 47 14 | th St | NW Wa | ash: | ington, I | OC 20010 Approximate Interval |
| Physic | | | failure. List only one cause on each line. | | | | | | a1103t, 2 | shook, or heart | Between Onset and Death |
| Exami | | | Immediate Cause (Final disease or condition resulting in death) a. Atherosc: Due to (or as a con | <u>lerotic</u> | Cardi | ovascu | lar Dis | sease | | | |
| 15 | | | Sequentially list conditions, b | , | | | | | | | |
| | | iner | if any, leading to immediate Due to (or as a con | sequence of): | | | | | | | |
| l | 2 _ | Examine | (Disease or injury that initiated events resulting in death) Last | sequence of): | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | transit | a E | d | | | 000 7 | 16 10 | | | | |
|) be exe | g physician a the burial - | Medical | ■ MENDED AMENDED 23 | | | 929 / | 16-12 | sm | | | |
| 3760, fficate be | g phys | M/G | IF FEMALE: 23c. If yes, outcomes 1 Live birth | ome of pregnar | | al death 3 | Ectopic | pregnancy | | 23d. Date of deliver Month | y Day Year |
| Box 687 | e attending j for use as th | icia | past 12 months? | at time of death | = | er (Specify) | | | | | |
| Be deat | 유명 | Physician/ | 1 Yes 2 No 9 Unknown 9 Unknown | M. L. A A | ultime in the cu | adorbino cous | given in Bor | 11 23e D | id tobacı | co use contribute to | the cause of death? |
| Division of Vital Records, P.O. tal o Attending Physician: The law requires that the safer deata. | ned by detach | by | Part II. Other significant conditions contributing to dea | ith but not resu | inting in the u | idenying cause | giverilirean | | | | bably 4 Unknown |
| duires | uld be | ted | | | | | | 24a. W | | | utopsy findings available |
| COTC | has be | Completed | | | | | | pe | utopsy erformed | death? | completion of cause of |
| . The | After this certificate uneral director, page | | 25. Was case referred to medical | | | 26 Pla | ce of Death (| Check only one) | es 2 | No 1 ✓ Y | es 2 No |
| ician i | is cert lirecto | Be | examiner? Hospital: | ient 2 Ef | R/Outpatient | | - | | Res | idence 6 🗸 Othe | er: Scene |
| of \ | fter th | ٤ | 27. Manner of Death 28a. Date of Ir | jury 28 | Bb. Time of Ir | jury 28c. In | jury at Work? | 28d. Descri | be how | injury occurred | |
| Eath in | the fu | ţ | Natural 5 Pending Accident Investigation | , , | | 1 | Yes 2 | - 11 | | | |
| ivis o At affer d | D ec | Certification: | 3 Suicide 6 Could not be 28e. Place of | Injury - At home | e, farm, stree | t, factory, office | building, etc | | on (Stree n, State) | | ural Route Number, City |
| Spital hours | filled | Se | 4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of | | | | | | | | tod |
| Division To the Hospital of Attend within 24 hours af er deata | To the Funeral D ector: After this certificate has been completely filled i by the funeral director, page 2 should | <u>s</u> | one) 2 Medical Examiner: On the basis of ex | amination and/ | death occuri or investigati | ed at the time, on, in my opini | date and plac on, death occ | ce, and due to the durred at the time, d | ate and | place, and due to the | ne cause(s) |
| | | Medical | and manner state 29b. Signature and vitle of certifier | d | | 29c. Lice | nse number | | 29 | d. Date signed (Mo | onth, Day, Year) |
| 3 | 3 | ΠĒ | D-7) L. | | | 0.0 | C.M.E. | | J۱ | uly 6, 2012 | |
| | | | 30. Name and address of person who completed cause of | | | | | | | | |
| | | | Donna M. Vincenti, MD Assistant Med | | | | re Street, | Baltimore, MD | 21223 | 3 | |
| | S | tate | 31. Date filed (Month, Day, Year) 2. Regist | rar's Signature | fact | 1 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ June 22,2012 0330 а M Idamae P. Fagan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Clinton Futurecare Pineview Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 442-32-9625 76 1 □ M 2 🛣 F Director Sept. 8, 1935 Oklahoma items 23a or 28a-f show ier must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Charles Waldorf 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20603 U.S.A 3680 Elsa Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Year or Dates White Specify. 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Housewife Own Home Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Hull Nickerson Fannie Mable Bashum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3680 Elsa Ave. Waldorf, MD 20603 Samuel Leeson (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2XX Cremation 3 Removal from State Lee Crematory June 23, 2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. MO0257 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on q th line. Approximate Interval Between Immediate Cause (Final Ph_{sician/} disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Unidentity Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Was deceue..., in the past 12 month 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Month Year Pregnant at time of death signed by the at Id be detached for 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ျှ this within 24 hours after ucca...

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? iniury Natural Accident 5 Pending Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

29b. Signature and title

person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1440 June 22 2012 Joseph B. Giza, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Crisfield 201 Hall Highway If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 □ F 78 27,1934 Maryland 216-30-5822 March Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d, Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Somerset Westover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be 7704 Riverview Road 21871 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1953 -55 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Security Officer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tillie Pelagia Giza John Giza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7704 Riverview Road, Westover, Md. Frances M, Giza Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 06/26/2012 Salisbury, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave. Princess Anne. Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) h. Enter the disease, or complications the ock, or heart failure. List only one cause of Veu Morr Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease 11 july) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 2 No 9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ≥ 12 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an MOLSID 1□ Yes 2□No 26. Place of Death Check onl one funeral director. 25. Was case referred to medical examiner? Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 1 | Inpatient After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Seath Injury (Month, Day Year) Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 30, 2012 1835 Physician/ Vishnu Dutt Grover Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Hospital 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min 1 1 Month Bay, 1 **√**M 2 □ F T926 Pakistan 85 218-84-8957 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland notified at Director 1 Yes 2 No 28a-f Leonardtown Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or Funeral United States 20650 22955 Abell Street ral", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Black White, etc. Armed Force 1 Never Married 2 Married þ Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar once. Specify: East Indian If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည Khem Bai Wadhwa Narain Dass Grover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25965 Point Lookout Road, Leonardtown, Maryland 20650 Renu Grover-Daughter-in-law 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/03/2012 | Charlotte Hall, Maryland Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundral Servic Oceans artivosoi Kathleen A. Santivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NEVMENIA Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) ARTERY 16mm **Examiner** CORONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) a | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUC 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56096

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

JUL 0 3 2012

35

7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASPANAC S. Gru (7)1811 MECULIFIE'S MUNICON MI)

れか

egistrar's Signature

| 12-04739 William Blaine (| Grah | | or Print in Black of Maryland / De | | | | | .egibl | e. | |
|---|----------------|--|---|--------------------|---------------------------------------|--------------------|----------------------|------------------|--|-------------------------|
| vviiiam Blamo | J. Q. | 1- For State | | ertificate d | | no mentar | rrygierie | | 201 | 2 222 |
| Physici | an/ | Registrar 1. Decedent's Name (First, Middle,Las | | | | | 2. Date of D | Reg. No. eath | <u> </u> | 3. Time of Death |
| Medical Exam | | William Blaine | Graham, Jr. | | | | Month June 23 | Day 2012 | Year | 2330 hrs |
| | | 4a. Facility Name (if not institution, give | e street and number) | | 4b. City, Town, o | or Location of De | | | c. County of Death | |
| | | Calvert Memorial | | | Prince Fre | ederick | | | Calvert | |
| Funeral | | Social Security Number 6. Security Number | ex 7. Age (In yr | s. last birthday) | If Under 1 Ye | | | Birth (MM | (DD/YYYY) 9. Birl Foreig | hplace (State or |
| Director | | 578-90-4897 | M 2□F 39 | Υ | | lys Hours I | Min. 02/0 | 07/19 | 73 | untry) Maryland |
| Ą | | Usual Residence of Decedent | | | | | | | | |
| W an | | 10a, State 10b. County | | ity, Town or Loc | ation | | | | | 10d. Inside City Limits |
| Maryland 28a-f show d at once. | tor | Maryland Calvert 10e. Street and Number | Lus | sby | | | | | | 1 Yes 2 ⅓ No |
| Mar r 28a | Director | | • | | 10f. Zip Code | | | | zen of What Cour | - |
| death with the Maryland or items 23a or 28a-f sho must be notified at once. | | 1153 San Rafael R | | | 20657 | | | | ted Stat | |
| ath w | Funera | 11. Marital Status 1 ※ Never Married 2 Married | 12. Was Decedent Ever in Armed Forces? |) If | as Decedent of H Yes, specify Cuba | | | No- | Race - Americ White, etc. | can Indian, Black, |
| er de | | | 1 Yes 2 No | | Yes 2 ∰ N | o specify: | | | Specify: Whi | |
| urs afi tural' | d by | 15. Decedent's Education (Specify or | or Dates: | _ | ent's Usual Occup | | of work done | 16b. H | Specify: Whi | |
| 72 hor | etec | Elementary/Secondary (0-12) | College (1-4 or 5+) | | most of working lif | | | | | • |
| 036 ithin ane. | Completed | 9 | | Lab | orer | | | Re | sidential | Construction |
| 5-0 Hed w | | 17. Father's Name (First, Middle, Last) | | | | 18.Mother's Na | me (First, Middle | e, Maiden | Surname) | |
| MD 21215-0036 ad 2 should be filed within 7 ulth and Mental Hygiene. m 27 is marked other than aumatic event, the <u>Medica</u> | Be | William Blaine G | | | | | ara Lynı | | | |
| Shoulc shoulc is m | ٢ | 19a. Informant's Name/Relationship (T | | | | | | | ty or Town, State, | Zip Code) |
| s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once | | Barbara D. Dimmic | | | San Raf | | Date | <u> </u> | Location - City or | Farry Chata |
| Ore of He If it | | 1 Burial 2 🔆 Cremation 3 | | crematory or o | | | | 200.1 | Location - City of | Town, State |
| Baltimore, MD 21215-0036 pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. | | 4 Donation 5 Other Specify: | | | in Crematoi | | 6/26/2012 | A1 | exandria, | Virginia |
| Bal Sermit Mpor injury | | 21 Signature of Funeral Service Licen | See | | Name and Addres | | D 4 D 0 | D | 600 T 1 | MD 000 57 |
| Physician | - " | 23a. Part I. Enter the disease, or comp | lications that caused the dea | ith. Do not enter | the mode of dvino | al nome, | c or respiratory | BOX arrest sho | ock or beart | Approximate Interval |
| /Medical | | failure. List only one cause on ea | ch line. | an Boriot oritor | and mode of dying | g, oddir do odraid | o or respiratory | arrost, sire | on, or near | Between Onset and Death |
| Examiner | | 1141 141 1 1 1 1 1 | Hanging Due to (or as a consequence | of): | | | | | | Death |
| | | Sequentially list conditions, b. | | , | | | | | | |
| | ner | | Due to (or as a consequence | of): | | | | | | |
| 9 | Examiner | (Disease or injury that initiated C. | Due to (or as a consequence | of): | | | | | | |
| executed an and al - transit | | d. | | | | | | | | |
| e exercian a | dical | UNPENDED | AMENDED | | _ | | | | | |
| 760 cate b | Š | IF FEMALE: | 23c. If yes, outcome of pre | egnancy | | | | 230 | d. Date of delivery | |
| 68 certifi nding se as 1 | ä | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth Pregnant at time of | death - | etal death 3 | Ectopic preg | nancy | | Month D | ay Year |
| 30X Jeath e atte | Physician/Med | 1 Yes 2 No 9 Unknown | | death 5 C | ther (Specify) | | | 1 | | |
| cords, P.O. Box 68760, Iaw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit | | Part II. Other significant conditions | contributing to death but no | t resulting in the | underlying cause | given in Part I. | 23e. Dio | tobaccoι | use contribute to the | he cause of death? |
| es the signed be der | ğ | | | | | | 1 🔲 Y | es 2 🗸 | No 3 Proba | ably 4 Unknown |
| rds requir | Completed | | | | | | 24a. Wa | | | opsy findings available |
| e law | Ę | | | | | | per | opsy formed? | death? | empletion of cause of |
| tal Reco | | 25. Was case referred to medical | | | 26 Plac | e of Death (Chec | | 2 ✓ No | 1 Yes | 2 No |
| /ita | o Be | | ospital: 1 Inpatient 2 | ✓ ER/Outpatien | | Othor: | sing Home 5 | Resider | nce 6 Other: | |
| ing Phy After th | - | 27. Manner of Death | 28a. Date of Injury FOUND: | 28b. Time of | | ury at Work? | 28d. Describ | e how inju | ry occurred | |
| OD endin ath. or: A | Certification: | 1 Natural 5 Pending | Lun 00 0040 | FOUND: 2237 hrs | 1 | Yes 2 🗸 No | Subject ha | anged s | elf | |
| VISI or Att fter de fter de in by | <u></u> | 2 Accident Investigation 3 Suicide 6 Could not be | 20a Diago of Injury At | | et, factory, office | building, etc. | | | nd Number or Rura | al Route Number, City |
| Dipital ours a cral I | 동 | 4 Homicide determined | | mily Home | | | or Town 11534 San | Rafael R | oad, Lusby, MD | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be fain 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician pletely filled in by the funeral director, page 2 should be detached for use as the burn | | 29a. Certifier (Check only 1 Certifying Physicial | an: To the best of my knowle | edge, death occu | rred at the time, d | late and place, a | nd due to the ca | use(s) and | d manner as state | d. |
| Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page | Medical | | On the basis of examination and manner stated. | and/or investiga | ition, in my opinioi | n, death occurre | d at the time, da | e and plac | ce, and due to the | cause(s) |
| | Σ | 29b Signature and title of certifier | 000 | | 29c. Licens | | | | Date signed (Mont | h, Day, Year) |
| | | Totalla- | - tolle | سر مع | O.C. | .M.E. | | June | 24, 2012 | |
| 10.01 | | 30. Name and address of person who o | | | 000 14/ 5 | | D-16 | 4D 046 | 22 | |
| dow 2 | | Patricia Aronica-Pollak MD | | | 900 W. Baltin | more Street, | Baltimore, | NU 212: | 23 | |
| St Regist | | 31. Date filed (Month, Day Year) | 32. Registrar's Signa | aure & L | a Kad | | | | | |

OCME

| | | | State of Maryland / Dep | | ∕lental Hygie | ne | 00010 | | | | | |
|---------------------|--|----------------|--|--|---|--|---|--|--|--|--|--|
| | | _1 | negistrat | rtificate of Death | Reg | . No. 2016 | 2 22242 | | | | | |
| | Physicia | _ | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death June 16, | 2012 Year | 3. Time of Death 1920 p M | | | | | |
| | Medic | al - | John L. Gray, III 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | June 10, | 4c. County of Death | | | | | | |
|) | Examin | er ' | Holy Cross Hospital | Silver Spring | | Montgomer | | | | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, | | 8. Date of Birth (Month, Day, Ye | 9. Birth | place (State or Foreign | | | | | |
| 100 | Director | Ŀ | 464-34-7480 1 IXM 2 □ F 83 Yrs. | Months Days Flours Willing | Feb. 19,1 | | ton, TX | | | | | |
| ,,, | how at | 'n | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L | ocation | | | 10d. Inside City Limits | | | | | |
| | larylar 3a-f si ified | Director | DC N/A Washingt | on | | | 1 X Yes 2 □ No | | | | | |
| | the M | اَقَا | 10e. Street and Number | 10f. Zip Code | | g. Citizen of What Cou | | | | | | |
| | s 23a | Funeral | 1424 Juniper Street, N.W. | 20012 | | nited Stat | | | | | | |
| Maryland 21215-0036 | e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates, | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ameri Black, White, Specify: B1 | | | | | | |
| 0-0 | hour natur dical | Completed | 15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv | edent's Usual Occupation e kind of work done during most of work | dna I | 6b. Kind of Business/li | | | | | | |
| 21 | nin 72 ne. :han " | m l | Elementary/Secondary (0-12) College (1-4 or 5+) | DO NOT use retired) | | John Gray | 1 | | | | | |
| 2 | d with | اما | 17. Father's Name (First, Middle, Last) | hitect 18. Mother's Nan | ne (First, Middle, Mair | A880C | lates | | | | | |
| and | be file ental I ked o ic eve | 은 | John L. Gray | Viola J | | , | | | | | | |
| ary | 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than "fitem traumatic event, the Mec | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma | ling Address (Street and Number or Ru | al Route Number, Ci | ty or Town, State, Zip | Code) | | | | | |
| Z. | nd 2 sl salth a n 27 i | | Hima Oldy/Will | Juniper Street, | | | | | | | | |
| Baltimore, | ge 1 ar it of He : If iter or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr | position (Name of ematory or other place) | | oc. Location - City or | | | | | | |
| Ę | t. Pag tment rtant: | | 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapea | ke Crematory 6/30 | /2012 Be | eltsville, | | | | | | |
| Bal | permit. Page 1 a Department of H Important: If ite any injury or ot once. | | Indre Thompson | 22. Name and Address of Facility Mc | e, N.W. Wa | sh., D.C. | | | | | | |
| - J | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Cardiovascular Diseasé | | | | | | | | | | | |
| 1 | Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | | | | | | |
| | 1 | ě | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | |
| | te be executed hysician and the burial-transit | dical Examine | cause. Enter Underlying Cause (Disease or injury | | | | | | | | | |
| | exect an an irial-tr | ĕ | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| 9 | te be hysici | dica | d | | | | | | | | | |
| 68760 | ertifica ding p se as 1 | /Me | IF FEMALE: 23c. If yes, outcome of pregnancy | | | 23d. Date of deli | iverv | | | | | |
| Box (| hat the death certificat ed by the attending ph detached for use as th | Physician/Med | in the past 12 months? 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 | Control Contro | | Month | Day Year | | | | | |
| O. B | the di by the tacher | hys | 9 Unknown | A Line of the Book I | | | the same of death? | | | | | |
| ds, P.O. | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transity. | Completed by F | Part II. Other significant conditions contributing to death but not resulting in the Hypertension | e underlying cause given in Part i. | | cco use contribute to | obably 4 X Unknown | | | | | |
| Records, | aw rec as be | uple | Diabetes | | 24a. Was an autopsy performe | prior to d | copsy findings available completion of cause of | | | | | |
| Re | The law cate has page 2 | ပ္ပြ | Dementia | | 1 ☐ Yes 2 | | 2 🗆 No | | | | | |
| ita | ician: The certificate rector, pag | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 XFR/Outpai | 26. Place of Death (Che | | 0 | | | | | | |
| of Vital | Attending Physician: or death. ector: After this certific by the funeral director, | e: To | 27. Manner of Death 28a. Date of injury 28b. Time | of 28c. Injury at | 28d. Describe how | ce 6 Other (Speci injury occurred | | | | | | |
| on C | ttending I death. tor; After y the funer | icat | 1 Natural 5 Pending (Month, Day, Year) injung 2 Accident Investigation | work? 1 ☐ Yes 2 ☐ No | | | | | | | | |
| Division | l or Atten after deat Director; I in by the | Certificate: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office | 28f. Location (Stree City or Town, S | et and Number or Rui State) | ral Route Number, | | | | | |
| | ours a ours a leral D | | 29a. Certifier Certifying Physician: To the best of my knowledge, dear | h occurred at the time, date and place. | and due to the cause | e(s) and manner as st | ated. | | | | | |
| | To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b | Medical | Check only only on the basis of examination and/or in only one of the basis of examination and/or in only one of the basis of examination and/or in only one of the basis of examination and/or in only one of the basis of examination and/or in only one of the basis of examination and/or in only one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and/or in one of the basis of examination and one of the basis o | estigation, in my opinion, death occurred | at the time, date and | place, and due to the | cause(s) and manner stated. | | | | | |
| | So the state of th | - | 29b. Signature and title of certifier | 29c. License number | | d. Date signed (Month | | | | | | |
| | U | | Jenn- | D28656 | Ju | ine 19, 20 | 12 | | | | | |
| 200 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Ravi Passi 15245 Shady Grove Ro | | ckville, N | Ф 20850 | | | | | | |
| | Sta Registi | | 31. Date filed (Month, Pay, Year) 32. Registrar's Signature | arles. | | | | | | | | |

DHMH 17 Rev 06-2011

| | | | For State Registrar | State of Maryland | | rtment of H | | | iene _{eg. No.} 2 | 012 | 22243 |
|--------------------------------|---|------------------|--|--|---------------------|---|---|---|--------------------------------|---------------------------------|---|
| | Physicia | | 1. Decedent's Name (First, Middle, Last) Sheryl | Gilber | t | | | 2. Date of Death | h | 2 ^{rear} | 3. Time of Death 9:00a M |
| | Medic Examin | | 4a. Facility Name (if not institution, give stre 5402 Surrey Str | | | 4b. City, Town, or Chevy | Location of Death | | 4c. County Mon | of Death | ery |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 | 7. Age (In yrs. last) | birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth 9 (Mantin, Das) | 944 | 9. Birthp V £o≱ n | olace (State or Foreign Yinia |
| | /land f show ed at | tor | Usual Residence of Decedent | erv 10c. City, To | own or Loca | ation Chase | | | | 1 | 0d. Inside City Limits |
| | ith the Mary 3a or 28a- t be notifie | Funeral Director | 10e. Street and Number 5402 Surrey Sti | | | 10f. Zip Code 2081 | 5 | 1 | 0g. Citizen of U | What Cour | 1 Yes 2 No |
| 9036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am propriate If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ρ | 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced | 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. | 1 | as Decedent of His Yes, specify Cubar | spanic Origin? (Spe n, Mexican, Puerto Spec <i>ify:</i> | cify Yes or No- Rican, etc.) | | ce - Americ ck, White, Wh | |
| Baltimore, Maryland 21215-0036 | vithin 72 hou lene. r than "natu the Medica | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12) | | (Give ki | ent's Usual Occupa ind of work done d NOT use retired) Math Tu | uring most of work | ing | 16b. Kind of B Educ Math | usiness Ind atic emat | |
| land | l be filed w lental Hyg rked othe tic event, | To Be | 17. Father's Name (First, Middle, Last) Milton Gilbert | • | | | 18. Mother's Name Ruth M | e (First, Middle, M ayersor | faiden Surnam 1 | e) | |
| Mary | d 2 should alth and M 27 is ma er traumal | ĥ | 19a. Informant's Name/Relationship (Type, Peter Jaszi/Hus) | 1 | 19b. Mailing | Address (Street a | nd Number or Rura Street | Route Number, Chevy | City or Town, S Chase | State, Zip (| ^{Code)} 20815 |
| more, | Page 1 an nent of He ant: If item iry or othe | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) | com | etery, crem sape | ition (Name of atory or other place ake Cre | m. 6/26 | /2012 | | svil | le,Md |
| Balti | permit. Departr Importa any inju | | 21. Signature of Ry all Service Licente | AL SER ver Sp | VICE | ,P.A. ,Md20910 | | | | | |
| | Ph_sician/ | | 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one of Immediate Cause (Final disease or condition | st, | | Approximate Interval Between Onset and Death | | | | | |
| | Medical Examiner | | resulting in death) | Metastatic Due to (or as a consequen | | 2100010 | 04.1002 | | | | |
| | ited d | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury | Due to (or as a consequen | be vij. | | | | | | |
| 90 | te be executed hysician and he burid the form | dical Ex | that initiated events resulting in death) Last | Due to (or as a consequen | ce of): | | | | | | |
| . Box 6876 | ath certifica attending pl for use as tl | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal d 4 Pregnant at time of dea g Unknown | eath 3 🗌 | Ectopic pregnanc Other (specify) | у | | | ate of deliver | ery Day Year |
| s, P.O. | requires that the de been signed by the should be detached | 5 | Part II. Other significant conditions control | ributing to death but not resulti | ng in the ur | nderlying cause giv | en in Part I. | | | | ne cause of death? |
| Division of Vital Records, | The law requate has beer page 2 shou | Completed | | | | | | 24a. Was ar autops perforr 1 \(\sum \) Yes | SV | Were auto prior to co death? | psy findings available mpletion of cause of |
| Vital | hysician: The lar his certificate ha I director, page 2 | To Be | 25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2\(\text{X} \) No | spital: 1 Inpatient 2 EF | l/Outpatien | Othe | ace of Death (Checker: 4 Nursing Ho | k only one) ome 5 🔀 Reside | ence 6 Oth | ner (Specify | ······································ |
| on of | nding Ph ath. r: After th ne funeral | Certificate: | 27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident □ Investigation | 28a. Date of injury (Month, Day, Year) | b. Time of injury | 28c. Injury work M 1 | | 28d. Describe ho | w injury occur | red | |
| Divisi | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi Dompleted filled in by the funeral | | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home building, etc. (Specify) | e, farm, stre | et, factory, office | | 28f. Location (St. City or Town | | er or Rura | Route Number, |
| | he Hospi in 24 hou he Funera pleted fill | Medical | (Check 2 Medical Examine) | an: To the best of my knowled r: On the basis of examination ar Practioner: To the best of my kn | nd/or investi | gation, in my opinio | n, death occurred a | t the time, date an | d place, and du | ue to the ca | use(s) and manner stated. |
| | Fare Services | | 29b. Signature and title of certifier | M | | 29c. License | number 033293 | 2 | 9d. Date signe June | | |
| | | | 30. Name and address of person who com Frederick P.Sn | npleted cause of death (Item 23 nith MD 545 | a) (Type, P | rint) sconsin | Ave #1 | 300 Che | evy Ch | ase, | Md 20815 |
| | Sta Registra | | 31. Date filed (Month, Day, Year) JUN 27 2012 | 32. Registrar's Signature | park | | | | | | |

| Amend per l | mended #19b, n1s, 06/26/12, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. er FD, Allegany Co. State of Maryland / Department of Health and Mental Hygiene | | | | | | | | | | | | | | | |
|---|--|-------------------|--|-----------------------------------|--|--------------|------------------------|-------------------------------|--------------------------|-----------------------------------|-------------|------------------------------|-----------|--|-------------|--|
| • | | , | For State | | State | or iviary | | epartm Certific | | | na ivie | ental Hy | Reg. N | 20 | 12 | 22244 |
| | | | Registrar 1. Decedent's Nam | e (First, Middle, I | _ast) | | | 00/11/10 | 410 07 1 | Journ | | 2. Date of De | | 0 0 | 16 | 3. Time of Death |
| - | Physicia Medic | | RICHARD | BRIAN (| GORNALL | | | | | | | Month 06 | 22 | ay 20 | Year 12 | 12:27 P. ^M |
| | Examir | | 4a. Facility Name (if | _ | | nber) | | 1 | - | r Location of | Death | | 40 | c. County o | | |
| | Funeral | | 5. Social Security N | ford Sta | . Sex | 7. Age (In | yrs. last birth | | Cumber | | 4 Hrs. | 8. Date of Bi | rth | ALLE | gany | lace (State or Foreign |
| | Director | | 215-08- Usual Residence | 1232 | 1 X M 2 □ F | | 0.7 | rs. Mont | | Hours | Min. | (Month, Di 05/18/ | ay, Year) | | Mary | try) |
| | /land f shov ed at | ţoţ | 10a. State | 10b. County | | 100 | c. City, Town | or Location | | | | | | | 1 | 0d. Inside City Limits |
| | Many 28a- | Director | MD | Alleg | any | | Cumbe: | | | | | | | | | 1 X Yes 2 □ No |
| | ith the | ral | 10e. Street and Nur | _{nber} ford Str | oot | | | 101 | . Zip Code 2150 | 2 | | | | itizen of W | | try? |
| | ems ems | Funeral | 11. Marital Status | | 12. Was Dece | | in U.S. | 13. Was De | | lispanic Origir an, Mexican, I | n? (Speci | ify Yes or No- | | 14. Race | | an Indian. |
| Maryland 21215-0036 | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 1 Never Marr | | | 2 No | -2000 | | specify Cuba s 2 👿 No | | Puerto Ri | ican, etc.) | | | White, e | etc. |
| 2-(| "natu "natu edica | plet | (Spe | 15. Decedent's ecify only highest | Education grade completed) | | | Decedent's l 'Give kind of | work done | during most o | of working | 9 | 16b. l | Kind of Bus | siness/Inc | dustry |
| 121 | ithin 7 ene. r than | Completed | Elementary/Seco | ondary (0-12) | College (1 | -4 or 5+) | - 1 | ife. DO NOT | _ ′ | dmissi | ons | |] | Nursi | no H | ome |
| ld 2 | Hygi othe | Be | 17. Father's Name (| First, Middle, Las | it) | | | | 01 11 | | | First, Middle | | | | |
| ylar | ld be f Menta arked | 은 | Richard | Royce C | ornall | | | | | Ru | th E | Edna Wright | | | | |
| , Mar | nd 2 shou ealth and n 27 is m | | 19a. Informant's Na Michelle | | (Type, Print) in Gorna1 | .1/Wif | 100 | - | | and Number o | | | | | | ode) 2541 12- ings,WV |
| Baltimore, | Cemetery crematory or other place | | | | | | | | | | | Location - (Cumbe | | | | |
| altir | permit. Page Department of Important: If any injury or once. | - 0 | 21. Signature of Fu | | en ee | | , dinber | | | ss of Facility | | - | 1 | | | |
| ä | an Dec | - 7 | Year | Q 0), | upch | uc | / | 202 | Gree | ne St. | , Cu | mber1a | and, | MD 2 | 1502 | 1 • 11 • |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | | | | | | | | | | | rrest, | | 5 | Approximate Interval Between Onset and Death | | |
| 7 | Medical Examiner | ı | resulting in death) | 1 | Due to | (or as a cor | nsequence of |): | | | | | | | | |
| | | ner | Sequentially list co if any, leading to in | nmediate | b. — Due to | or as a cor | nsequence of |): | | | | | | | | |
| | executed ian and irial-transit | Examiner | cause. Enter Under Cause (Disease or that initiated events | injury | с | | | | | | | | | | | |
| | e exec cian au purial-1 | | resulting in death) | Last | Due to | or as a cor | nsequence of |): | | | | | | | | |
| 68760 | tificate be ng physici as the bu | edic | | | d | | | | | | | | | | | |
| (687 | Hospital or Attending Physician: The law requires that the death certificate be 74 hours after death certificate be 74 hours after death certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the but the funeral director. | Physician/Medical | IF FEMALE: 23b. Was decedent | | 23c. If yes, out | | egnancy Fetal death | 3 ☐ Ector | oic pregnanc | 21/ | | | | 23d. Date | e of delive | ery |
| Вох | is that the death cert igned by the attendir be detached for use | ysici | in the past 12 in the past 12 in 1 Yes 2 Unknown | No | | nant at tim | | 5 Othe | | - y | | | | Mon | th | Day Year |
| P.O. | hat the | by Ph | Part II. Other signif | icant conditions | s contributing to d | eath but no | ot resulting in | the underlyi | ng cause gi | ven in Part I. | | 23e. Did 1 | tobacco | use contrib | oute to th | e cause of death? |
| 18,1 | requires t been sign should be | ed b | | | | | | | | | | 1 🗆 | Yes 2 | No : | 3 🗌 Prob | ably 4 🗆 Unknown |
| Records, | aw red as bee 2 sho | Completed | | | | | | | | | | 24a. Was | | | | psy findings available inpletion of cause of |
| Re | The law cate has l | Con | | | | | | | | | | perfe 1 🗀 Yes | ormed? | de | eath? | · |
| ta | itcian: The certificate rector, pag | Be | 25. Was case referre | | Hospital: | | | | Oth | lace of Death | (Check o | only one) | | | | <u> </u> |
| of Vital | Phys r this eral dii | 9: To | 1 Yes 2 L 27. Manner of Death | No ' | 28a. Date | of injury | 2 ER/Out 28b. Ti | me of | DOA DUIT | 4 L Nurs | | e 5 Resi | | | | |
| on C | nding ath. r: Afte re fun | icat | 1 ☐ Natural 2 ☐ Accident | 5 Pending Investigat | 1 ~ 1 | th, Day, Yea | | ury M | work | | | TE | ر ک ا | 26 | 4,, | MSE UF |
| Division | r Atte ter dea rectol | Certificate: | 2 ☐ Suicide 4 ☐ Homicide | 6 Could no determine | t be 28e. Place | of Injury - | At home, farr | n, street, fac | tory, office | | 28 | Bf. Location (City or To | Street ar | nd Number | or Rural | Route Number, |
| وَ | oital o | | | | <u> </u> | OM | 8 | | | | | 511 | DE | 010 | PP | ST |
| | To the Hospital or Attending Physician: "In thin 24 hours after death as the Funeral Director: After this certification to the Funeral Director: After this certification properties of the funeral director, to make the funeral director, and the funeral director. | Medical | | Medical Exa | hysician: To the b a miner: On the bas yrac Prayditionar | is of exami | nation and/or | investigation | , in my opinie | on, death occu | urred at th | ne time, date | and place | e, and due | to the cau | se(s) and manner stated. |
| | To the within To the comp | 2 | 29b. Signature and | | - | | | | 29c. Licens | | | _ | | ate signed | | |
| | 6+ | | | 1 | /~~ | _ | | | (6)- | 09 | 12 | } | 6 | 12: | 2/1 | |
| | nes | | 30. Name Indiad | ow, M.D. | o completed caus Deputy | e of death | (Item 23a) (T 124 W | pe, Print) Thir | d St. | , Cumb | erla | nd, MD |) 21 | 1502 | | |
| | Sta Registra | | 31. Date filed (Month | 26201 | 2 Sene | egistrar's S | ignature | What | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 June 29 1045 Physician/ Gormer Lenore Medical 4a. Facility Name (if not institution, give street and number)
Allegany Health Nursing & Rehab 4b. City, Town, or Location of Death Cumberland 4c. County of Death Allegany **Examiner** Ctr 9. Birthplace (State or Foreign Age (In yrs. last birthday) 84 Yrs. If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) 01/25/1928 **Funeral** Country) Pennsylvania Months Days Hours Min. 1 □ M 2 💢 F 208-22-8137 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant; If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Cumberland Allegany MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Sherwood Drive (P.O. Box 76) 21502 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking President 18. Mother's Name (First, Middle, Maiden Surname)
Weltner Be 17. Father's Name (First, Middle, Last)
Clarence Fisher Luther ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12513 Bedford Road, NE, Cumberland, MD J. Scott Blankenship / Friend 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place)
Cumberland Crematory 07/02/2012 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Adams Family Funeral Home, F.A. 21 Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 23a. Part I cinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pnysician TE resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ____ 3 Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed 2 No 1 Tes 26. Place of Death (Check only one) After this certific funeral director, Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide death. Investigation 6 Could not be 24 hours after deat Funeral Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signature a 201) 10 mel 30. Name and address of person who completed cause of death (Item 23) (Type, Print)
Robustiano J. Barrera, Jr., M.D., 21502 200 Glenn Street, Cumberland, MD

State Registrar 31. Date filed (Month, Day, Year) 32.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^MJun 14, ^D2012 Physician/ 3:15 PM™ Getson Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Corriganville Allegany 11927 Getson Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country)OH Feb 8, 4931 1 🗆 M 2 🔀 Director 279-28-5806 81 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location Director Allegany Corriganville MD 1 🗆 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21524 USA 11927 Getson Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes : 1 Yes 2 No Maryland 21215-0036 Specify white 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Getson Excavating Co co-owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Zver 2 Matthew Kotnyek Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9435 Pinetree Drive Lakes Wales FL 19a. Informant's Name/Relationship (Type, Print)
Belinda Malone 33898 daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ★ Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 6/19/2012 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Carrow In Furtheral Home, PA of Funeral Se ignatu 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1, Phter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer work? Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D0014812 3

State Registrar

JUN 20

DHMH 17 Rev 06-2011

909B Seten Drive Cumberland MD 21502

pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeffey Louis Holland 0311 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death TENINSULA REGIONAL MEDIEN Centu 544156414 VICIMIC 8. Date of Birth
(Month, Day, Year)
Feb. 17, Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 219-78-4157 Director 1 M 2 D F 50 1962 Maryland Usual Residence of Deceden 27 is marked other than "naturel", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Somerset Westover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7750 Riverview Road 21871 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seafood Waterman i end 2 should be filed wit f Health end Mental Hygie Item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Anne Parkinson Holland Granville Holland ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne P. Holland Mother 7750 Riverview Rd., Westover. Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairmount Cemetery : 06/27/2012 Fairmount, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause in each line.

Imm mate Cause (Final disease or condition Approximate Onset and Death Physician/ Due to (or as a con- uence of): Medical resulting in death) Examiner heren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burlel-transit Due to (or as a consequence of) resulting in death) Last anding physician of use es the burlei Physician/Medical Box 68760 this certificete hes been signed by the ettending rai director, page 2 should be deteched for use es IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗵 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Physin 24 hours efter death.

The Funeral Director: After this of pletely filled in by the funeral director is the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/\(\tilde{\Delta}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \(\tilde{\Delta}\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56093 23 12012 DR. UN Y. CHIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 EAST CARPOL STREET, SALISBURY, MD

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

JUN 2 8

32. Regi

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|----------------------------|--|-------------------------------|---|--------------------------------|----------------------------------|----------------------------------|--|----------------------|---|------------------------|---------------------|---|---|--|------------------|---------------------------------------|----------|
| | | | For State Registrar | | Stat | aryiani | yland / Department of Health and Men Certificate of Death | | | | | Reg. No. 2012 22249 | | | | | |
| | Physicia | m/ | 1. Decedent's Name | | | | 2. Date | | | | | | | | | | |
| | Medic | al | ZaKiyah | | | | | | June 4b. City, Town, or Location of Death | | | | 23 2012 8:50 P M | | | | \dashv |
| | Examin | er | 37275 I | | | Lar | | | Mechan | | St. Mary's | | | | | | |
| | Funeral Director | | 5. Social Security Number 2 1 3 77 7 3 6 5 Usual Residence of Decedent 6. Sex 1 □ M 2 ☒ F | | | | | st birthday) Yrs. | If Under 1 Year Months Days | ays Hours Min. (Month, | | | 9. Bit Day, Year) Co | | 9. Birth Coun | place (State or Foreign try) MD | |
| | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minorant: If item 27 is marked other than "natural", or items 20a or 28a-f show amyoring or other traumatic event, the Medical Examiner must be notified at once. | tor | 10a. State 10b. County | | | 10c. City, Town or Loc | | | | | | | | | 1 | Od. Inside City Limits | ٦ |
| 36 | | Jirec | MD St. Mary's | | | | M€ | echan: | icsville 10f. Zip Code | | | | 10.0 | | | 1 X Yes 2 ☐ No | _ |
| | | Funeral Director | 37275 Louis Thomas Lane | | | | | | 20659 | | | | 10g. Citizen of What Country? USA | | | | |
| | | by Fune | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | | | | | Vas Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2X No Specify: | | | | 14. Race - American Indian, Black, White, etc. | | | etc. | |
| 2-0 | | lete | 15. Decedent's Education (Specify only highest grade completed) | | | | | 16a. Deced | Decedent's Usual Occupation (Give kind of work done during most of working) | | | | | 16b. Kind of Business/Industry | | | |
| 21215-0036 | | Completed by | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | life. D | live kind of work done during most of working e. DO NOT use retired) udent | | | | | School | | | |
| d 2 | | Be | 17. Father's Name (First, Middle, Last) | | | | | | tenc | e (First, Middle, | le, Maiden Surname) | | | | | | |
| ylan | ild be fi Menta larked atic ev | To | Jesse Holland, Jr. | | | | | | LaKissha But | | | | | | | | |
| Maryland | permit. Page 1 and 2 shou Department of Health and Important; If item 27 is m any injury or other traum once. | | 19a. Informant's Na LaKissh | | | | r | | ng Address (Street of Louis | | | | | | | Code) 20659 e • MD | 1 |
| Jre, | | | 20a. Method of Disp | osition | ` | | 20b. P | lace of Dispo | sition (Name of natory or other place | | | Date | | ocation - C | | | |
| Baltimore, | | | 4 Donation 5 Other (Specify) Moses | | | | | | Cemetery 6/30/2012 | | | | | | | | |
| Bal | | | 21. Signature of Funeral Service Udensee 22. Name and Address of FacilityBriscoe-Tonic Funeral Hom 38576 Brett Way Mechanicsville, MD 2065 | | | | | | | | | | | | ļ | | |
| | hyvician/ | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death | | | | | | | | | | | | | | |
| 7 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | | resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | | Examiner | Sequentially list co if any, leading to in | b. Du | Due to (or as a consequence of): | | | | | | | | | | | | |
| | | Exan | Cause (Disease or that initiated event resulting in death) | S | c. Di | Due to (or as a consequence of): | | | | | | | | | ** | _ | |
| 09 | | dical | | | d | | | | | | | | | | - | | _ |
| Box 68760 | | Completed by Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome c 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown | | | | 2 Fetal death 3 Ectopic pregnancy | | | | | | 23d. Date of delivery Month Day Year | | | | |
| s, P.O. | | d by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 X No 3 Probably 4 U | | | | | | | | | | | 1 | | | |
| Division of Vital Records, | | Somplete | | | | | | | | pe | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | |
| ital | | Be | 25. Was case referred to medical examiner? | | | | | | | | | | s 🗆 Out | /C | | 7 | |
| n of V | | ate: To | 27. Manner of Death | 5 Pendir | ng | 28a. Date of inju (Month, Day | | 28b. Time of injury | 28c. Injur work | y at k? | at 28d. Des | | cribe how injury occur | | | | |
| ivisio | I or Atten after deat Director; d in by the | Certificate: | 2 Accident 3 Suicide 4 Homicide | Investi 6 Could determ | not be 28e. | De Diago of Injury At home form | | | | | | 28f. Location (Street and Number of City or Town, State) | | | or Rura | l Route Number, | |
| | To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | tuse(s) and manner state | ed. |
| _ | To the within 2 To the comple | - | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 -25 - 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 -25 - 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 -25 - 2016 31. Date filed (Month, Day, Year) 32 Registrar's Signature 33 Registrar's Signature 34 Registrar's Signature 36 April | | | | | | | | | | | | | | |
| | PA-I | | 30. Name and addr | ess of person | who completed | d cause of c | leath (Item | 23a) (Type, 1 | Print) 2120M | 00K | 121 | St. Le | eonardtown Man | | | | |
| | Sta | te | 31. Date filed (Mont | h, Day, Year) | 0040 | 32 Registr | ar's Signat | ture , | 21001 | | | | | | | 20030 | |
| | Registr | | | IUN 26 | 2012 | alnew | a p | 9. 40 | the | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2012 Linda Fay Hayes June 23 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Nursing & Rehab Fort Washington Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days April Day Yes Hours Mir 214-68-9317 56 Yrs. Maryland 1956 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Charles Bryans Road 1 🗆 Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7054 Detroiter Place U.S.A. 20616 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces:

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 2 **X**No 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced SpecifyWhite 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook & Bartender Restaurant permit, Page 1 and 2 should be filed vi Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 J. B. Hayes Lillian Pickeral 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 7054 Detroiter Place, Bryans Road, Md. 20616 Mark J. Hayes 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State reace of Disposition (Name of cemetery, crematory or other place) June 30^{Date} 2012 1 Burial 2 XCremation 3 Removal from State Metropolitan Funeral Service Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the d shock, or Heart fall bease, or complications that caused the death. Do not enter the mode of dying, liure. List only one cause on each line. ch as cardiac or respiratory arrest Onset and Death Immediate Cause Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner quence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence o Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🗗 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

egistrar's Signature

5 2012

7700 OLD BRANCH Rd.

Suit CLOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard 5:51P M Lee June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bowie Prince George's 3515 Malec Lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 1**X**XM 2□F 407-74-2274 57 Dec. 1, 1954 Kentucky or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ¥ Yes 2 □ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20715 3515 Malec Lane 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 2 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 tof Health and Mental Hyglene.
If item 27 is marked other than "ror other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Federal Government Image Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic. Mary Franklin Clifford Wayne Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Howard - Wife 3515 Malec Lane, Bowie, MD 20715 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 K Removal from State 6-23-2012 Resthaven Cemetery Louisville, KY 4 Donation 5 Other (Specify) Signature of Furtheral Service (22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Creutzfeld+ - JACOb Disease Priysician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burlal-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burla Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: After the fulling in by the fulling in the fullin 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Ms Ryupahlmo 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOU57465 6/20/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rajapakse MD 2835 SmimAV Baltimore 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:40 A M Physician/ Paul Leon Heitzenrater 2012 June Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Annapolis 940 Creek Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral April 20, Hours 208-30-1052 1940 Pennsylvania 72 Director 1 X M 2 □ F Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

Sant. If item 27 is marked other than "natural", or Items 23a or 28a-f show jury or other traumatic event, the Medical Exeminer must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Director Annapolis Anne Arundel Maryland 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 940 Creek Drive 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S.

Armed Forces?

1 KM/es 2 □ No

If Yes, Give

Year or Dates. 1959–63 Black, White, etc. 1 Never Married 2 MMarried ģ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Quality Assurance Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Julia Ethel Bodenhorn Harry J. Heitzenrater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 Creek Drive Annapolis, Maryland Ruth Heitzenrater/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 6/27/2012 Baltimore, Maryland Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician LANW disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician end I for use as the buriel-transit the Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 2 Accident 5 Pending To the Hospital or Attendin, within 24 hours after death, To the Funeral Director: Aft completely filled in by the fur Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of etifi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 4527

Registrar
DHMH 17 Rev 06-2011

State

30. Name and addr.

31. Date filed (Month

pleted cause of death (Item 23a) (Type, Print

32. Pegistrar's Signature

120141

2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Paula N. Holland Pauline Holland aka 2012 10:12 June 23 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens at Riderwood Village Silver P.G Spring Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Oct. 20, Year) 926 Months 577-30-1337 Washington, DC 85 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD P.G. Silver Spring 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral with 3160 Gracefield Road, 0G3112 20904 IISA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married δ hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working I Hygiene. Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Secretary should be filed with and Mental Hygien is marked other tl Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vidas Nakarada Mathilda Scholz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or when Kelly H. Weisgerber/Daughter 9514 Thornhill Road, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fort Lincoln 1 XBurial 2 Cremation 3 Removal from State June 28, 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cemetery Brentwood, MD Signature of Emeral Service Licen. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease End-Stage disease or condition month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Dun to for each consequence off day leading to in medicause. Enter Underlying B that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? ō 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsv perform death? ate 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 1XXNatural 5 Pending injury work? 1 🔲 Yes To the Hospital or Attendir within 24 hours after death.

Jo the Funeral Director: Af completed filled in by the fur 2 No after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to he cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) t 42633

State Registrar 3110 Gracefield Road, Silver Spring,

MD 20904

ddress of person who completed cause of death (Item 28a) (Type, Print)

32. Registrar's Signature

Julaine Harding, CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22254 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RONDA LYNN HENRY 1428 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 235-98-6517 1 🗆 M 2 🗓 F 54 06/28/1957 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Ridgeley 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26753 U.S.A. Buser Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cook & Server Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eileen Barbara Kreiger Robert Louis Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Leslie Henry/Husband P.O. Box 254, Ridgeley, WV 26753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restlawn Meml.Gardens 06/28/2012 LaVale, MD 22. Name and Address of Facility Upchurch Funeral Home 21. Signature of Funeral Service Lice 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metrotatic Physician/ brenst disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate l 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 124 hours after death.
Funeral Director: Af letely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier emacon, M.D June 24,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y2) WILLOW BROW FD- CLOMBERLAND MAD HUSAM SEMAAN -12501

DHMH 17 Rev 06-2011

Registrar

Registrar's Signatu

2012

Amended #1, nls, 06/26/12, per phy., Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 043 Physician/ Hastie -P- Ann Patricia Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)

A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours Mar 29 and 1937 163-30-3692 75 **Director** 1 □ M 2 🗗 F Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location aţ 10a. State Director notified Cumberland MD Allegany 1 X Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 0 ral", or items 23a or Examiner must be r Funeral 21502 USA 506 White Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) McIntyre's 7-Day Market clerk Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norma Opperman Louis Polentes 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip 14320 Valley Road NE Cumberland 19a. Informant's Name/Relationship (Type, Print) Lori A. Wolfe ์MD 21502 daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 ★ Burial 2 Cremation 3 Removal from State Forest Lawn Cemetery 6/21/2012 PΑ Johnstown 4 Denation 5 Other (Specify) 22. Name and carpens Full Eral Home, PA 21. Sign 108 Virginia Avenue: Cumberland, MD 21502 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ ceast disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of, sician and burial-transit Exam Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pocumonis 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an spiral or Attending Physician: The law ours after death.

eral Director. After this certificate has I filled in by the funeral director, page 2 % autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Hospital 1 🗌 Yes ၉ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at iniury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a the Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one)

State Registrar

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Blanche Marromatis M.D

JUN 2 0 2012

20066439

12502 Willaubrook Rd. Ste. 300 Cumberland, MD2150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Audrey Geneva Hart 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min 235-62-0986 Director 1 🗆 M 2 💢 F 83 06/21/1929 West Virginia 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f Braxton Frametown 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a 12577 Elk River Road 26623 USA ural", or items a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examin ury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify Completed 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. I other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Ernest Pratt Rollyson Bernice Rollvson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 788 Foxtown Road, David Hart / Son Accident. MD 21520 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Hart Family Cem. Department o Important: If any injury or 07/06/2012 Donation 5 Other (Specify) Clem, WV un at re of Fun al Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Plusidian/ 0 disease or condition C1.0 G Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a conse uence of cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 9 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation within 24 hours after death To the Funeral Director: 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 28, 2012 mel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD 21502

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUL U & CUIL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Second Paul Hyrkas June 22, 2012 | 9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 Yes 2 X No What Country? A. ce - American Indian, Black, site, etc. White Business/Industry AC/R ne) |
|--|--|
| 4a. Facility Name (if not institution, give street and number) 21050 Frederick Road 5. Social Security Number 219-02-2704 1 M 2 F 44. Security Number 219 | 9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 Yes 2 X No What Country? . A. ce - American Indian, Black, lite, etc. White Business/Industry AC/R ne) |
| Funeral Director 5. Social Security Number 219-02-2704 1 M 2 F 44 Yrs. 6. Sex 7. Age (In yrs. last birthday) Wonths Days Hours Min. June 18, 1966 Usual Residence of Decedent 10a. State 10b. County Marryl and Monts comery Gaithersburg | 9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 Yes 2 X No What Country? A. ce - American Indian, Black, site, etc. White Business/Industry AC/R ne) |
| Director 219-02-2704 1 M 2 F 44 Yrs. Months Days Hours Min. June 18, 1968 Usual Residence of Decedent 10a. State 10b. County Marxyl and Mont gomery Gaithersburg | Tod. Inside City Limits 1 |
| 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg | 1 Yes 2 No What Country? .A. ce - American Indian, Black, lite, etc. White Business/Industry AC/R ne) |
| Maryland Montgomery Gaithersburg 10e Street and Number 10f Zip Code 20882 U.S | What Country? A. ce - American Indian, Black, lite, etc. White Business/Industry AC/R ne) |
| 9834 Watkins Road 10. Street and Number 9834 Watkins Road 11. Marital Status 1 Never Married 2 Married 3 No specify: 1 Never Married 2 No specify: 1 Never Married 2 No specify: 1 Never Married 3 No specify: 1 Never Married 4 Divorced If Yes, Give Year or Dates: 1 No specify: 1 Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 No specify: 1 No specif | ce - American Indian, Black, lite, etc. White Business/Industry AC/R ne) |
| The proposition of the property of the propert | white White Business/Industry AC/R ne) Dwn, State, Zip Code) |
| Widowed 4 Divorced If Yes, Give Year or Dates: 1 | Business/Industry AC / R ne) own, State, Zip Code) |
| State of the state | own, State, Zip Code) |
| 17. Father's Name (First, Middle, Last) Ronald John Hyrkas 19a. Informant's Name/Relationship (Type, Print) Waren E. Hyrkas – Wife 18. Mother's Name (First, Middle, Maiden Surnan Margaret Howard 19a. Informant's Name/Relationship (Type, Print) Waren E. Hyrkas – Wife 18. Mother's Name (First, Middle, Maiden Surnan Margaret Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Toward Margaret Howard) 19c. Method of Disposition | own, State, Zip Code) |
| Ronald John hyrkas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To 19a. Mothed of Disposition 20a. Mothed of Disposition | |
| Karen E. Hyrkas – Wife 9834 Watkins Road, Gaithersburg, | Maryland 2088 |
| | n - City or Town, State |
| Crematory or other place) 1 XBurial 2 Cremation 3 Removal from State All Souls Cemetery 6/27/12 Germa | ntown, Maryland |
| 1 20401 Kidge Road, Damascus, Ma | ryland 208/2 |
| Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | |
| if any, leading to immediate cause. Enter Underlying Cause (Disease of kijury that kildlated events resulting in death) Last Due to (or as a consequence of): | |
| d. UNPENDED Day and a strict of the strict | |
| O. UNPENDED AMENDED IF FEMALE: 23d. Date | of delivery |
| 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (Specify) | Day Year |
| On the second se | ntribute to the cause of death? |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 23e. Did tobacco use cordinate the death part in the underlying cause given in Part I. 24e. Was an autopsy performed? | |
| Aecords The law require that been significant has | . Were autopsy findings available prior to completion of cause of death? |
| To be a second of the second | 1 Yes 2 No |
| 25. Was case referred to medical examiner? 1 Yes 2 No 280 Date of Injury 280 Date of I | Other: Scene |
| 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occu (Month, 2012) 28b. Time of Injury 2000 hrs 28d. Describe how injury occu 3000 hrs 2 V No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 236. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 236. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 236. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 236. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 237. Was an autopsy 1 | nber or Rural Route Number, City |
| 4 Homicide 29a. Certiffing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. | ner as stated. |
| Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29d. Date signature. | gned (Month, Day, Year) |
| Callell () O.C.M.E. June 23, | 2012 |
| 30. Name and address of person who completed cause of death (Item. 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | |
| State 31. Date filed (Month Day, Year) 2012 32. Registrar's Signature | |

Jure 20, 2617 1145 HARDING, HAZEL M rland 21215-0036

| | | | P | | | Print in I | | | | | | | | | ble. | | |
|----------------|--|-------------------|--|---|---|---|----------------------------------|-----------------------------|---------------------------------|--------------------------------------|--|---|---------------------------------|---------------------|--------------------|--|---------------|
| | | 1 | For State Registrar | | State of | Marylan | | artmen <i>tificate</i> | | | and IV | rientai Hy | /giene Reg. No | 200 | 12 | 222 | 58 |
| | Physicia Medic | | Decedent's Name (First, Market) Hazel Market | | rding | | | | | | | 2. Date of De Month June | Da | Day Year 2012 11:45 | | | |
| 7 | Examin | | 4a. Facility Name (if not institu | _ | | | - | 1 | | Location | of Death | | 4c. County of Death Montgomery | | | | |
| _ | Funeral | | Shady Grove 5. Social Security Number | If Under | 1 Year | ille If Under | | 8. Date of Bi | | | 9. Birthpl | ace (State or For | reign | | | | |
| | Director | | 218-16-0728 | Months | Days | Hours | Min. | (Month, Di | | y, Year) Country) 24 1923 Marylan | | | | | | | |
| | at w | ۱ | Usual Residence of Decede 10a. State 10b. Con | | | 10c. Cit | y, Town or Lo | cation | | <u>l.</u> | | | | | |)d. Inside City Li | mits |
| alvan Marth | larylar 3a-f sl tified | Director | MD | Montg | omery | | Gaith | ersbu | ırg | | | | | | | 1 Yes 2 | □No |
| | vith the N 23a or 28 st be no | | 10e. Street and Number 32 Dalmar S | | 10f. Zip | Code | 208 | 77 | | 10g. Ci | | hat Count | | | | | |
| | eath v tems er mu | Funeral | 11. Marital Status | S. 13.\ | Vas Deced | dent of Hi | spanic Ori | igin? (Spe | ecify Yes or No Rican, etc.) | - | 14. Race - American Indian, | | | | | | |
| s affer of | ırs after d ural", or i I Examin | ρ | 1 Never Married 2 3 Widowed 4 Divo | | I ☐ Yes | 2 X ANO | Specify | | | | Black, White, etc. Specify: White | | | | | | |
| 5 | 72 hou "natu ledica | Completed | 15. Dec (Specify only I | 16a. Deced | dent's Usua kind of wo O NOT use | rk done a | ation during mos | at of work | ing | 16b. Kind of Business/Industry | | | | | | | |
| 7 | vithin vithin vithin vithin vithen. It than the M | | Elementary/Secondary (0- | | memak | , | | | | | Own | Home | ∋ | | | | |
| and 2 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. San or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | To Be | 17. Father's Name (First, Middle Loy H. Sm | | 18. Mother's Name (First, Midd | | | | | | fle, Maiden Surname) Howard | | | | | | |
| | 12 should lith and M 27 is mai r traumat | | 19a. Informant's Name/Relat Katherine M | | | ıghter | 19b. Mailin 3329 | ng Address | Street a | and Numb | er or Rura Ija | al Route Numb MSVille | er, City o | r Town, Si aryla | tate, Zip C ind | ^{ode)} 21754 | |
| | of Health of Health If item 27 If other tr | | 20a. Method of Disposition | tion 3 \square Re | emoval from | | Place of Dispo cemetery, crer | osition (Nar matory or c | ne of other plac | re) | | Date | 1 | | City or To | | |
| altillio | permit. Page 1 Department of Important: If it any injury or o | | 1 | | | | | | | | | | | nia | | | |
| ם | permit. Departr Importa any inju | | 21. Signature Fune at Service-Li ns: 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 | | | | | | | | | | | | | | |
| | | Г | 23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final | e, or complic List only one | ations that cause on eac | aused the deat th line. | | | | | | | | | | Approximate Interval Betwee Onset and Deat | |
| 1 | Medical Examiner | | disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | | | <u></u> | | |
| | Ver der) | ner | Sequentially list conditions, | HONE OF | | | | | | | | | | | | | |
| | executed an and rial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | | | - | | | |
| | e exec cian a curial-i | | | | | | | | | | | | | | | | |
| 00/00 | cate b physi | ledic | | d. | | | | | ·vcc | | | | | | | | |
| DOX DO | The law requires that the death certificate be executed attentions are the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnan: in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown | | 3 Ectopic pregnancy 5 Other (specify) | | | | | | 23d. Dat | te of delive | ery Day Year | | | | |
| S, P.O. | ires that th signed by d be detac | by | Part II. Other significant co | nditions cont | ributing to de | eath but not re | sulting in the | underlying | cause gi | ven in Par | t I. | | | | | ne cause of death | |
| Vital Records, | he law requ te has beer age 2 shou | Completed | | | | | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings prior to completion of codeath? 1 Yes 2 No 1 Yes 2 No | | | | | lable e of |
| <u> </u> | ctor, p | Be C | 25. Was case referred to me examiner? | | anitali | | | | | | ath (Chec | k only one) | | | | | |
| | Physic this ce | 은 | 1 Yes 2 No | | | Inpatient 2 | ER/Outpatie | | | | | | | | | | |
| n or | ding F th. After funer | cate | 1 Natural 5 🗆 F | 1 Natural 5 Pending (Month, Day, Year) ir | | | | | | | □No | 26u, Describe | e how injury occurred | | | | |
| DIVISION | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certificate: | 3 Suicide 6 C 4 Homicide d | nome, farm, st | M 1 ☐ Yes 2 ☐ No street, factory, office 28f. Location (Single of Notice 28f. Location (Single of Notice) 28f. Location (Single of | | | | | | Street and Number or Rural Route Number, vn, State) | | | | | | |
| _ | e Hospita 124 hours e Funeral | Medical | (Check 2 Mel | ical Examine | r: On the bas | est of my know is of examination To the best of | on and/or inve | stigation, in | mv opini | on, death | occurred a | at the time, date | e and plac | ce, and du | e to the ca | use(s) and manne | er stated |
| | To th To th comp | | 29b. Signature and title | | 1 | MY | | 20 | n Licone | a number | | | 204 D | ate ciane | d (Month | Day Yearl | |
| | 2 | | 30. Name and address of pe | | | e of death (Ite | m 23a) (Type, | Print) | 721 | N D | (21) | te 278 | 3 | Packer | Tie, M | lizayind 20 | |
| | Sta | ate | 31. Date filed (Month Day, Y | 5hmrt | 32. | 2401 egistrar's Sign | ature | ann | 1 | u, | val | レクグ |) 12 | - | | 1 | <i>v</i> 3 - |
| | Registr | | JUN | % D ZU | 14 /4 | nous | 13. 19 | A BALLAN STAR | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day <u>Linda A</u> 12:40 A M Ivan Medical June 25. 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8816 Junaluska Terrace Clinton Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Hours **Director** 1 🗆 M 2 🕱 F 220_62_9257 60 Oct 4, 1951 Washington DC Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland 1 4 1 Prince George's Clinton ō 10e. Street and Number 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1 Funeral 8816 Junaluska Terrace 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4XX Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene D. Thomas Ada Erma Talbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ronald L. Thomas (brother) 117 Skinner Road, Four Oaks, NC 27524 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 26, 2012 Lee Crematory Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autops performed? Yes No death? 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident work? 1 ☐ Yes 2 ☐ No injury Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29d. Date signed (Month, Day, Year) 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) (EACH MI ANNAPOLIS PL KADIE 9500 31. Date filed (Mon: State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Darlene Jordan 5:50 a.₩. Sharon July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 □ M 2 🛣 F 213-56-6378 01/20/1949 Maryland Usual Residence of Decede 63 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🗶 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral "natural", or items 23a 21465 Knotts Drive 20619 United States · death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Preparation Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eleanor Kolb Elmer Joseph Kuster, Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Jordan/Husband Box 437, Great Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre07/05/2012 | Charlotte Hall, MD Brinsfield Funeral Home, P.A Signature of Funeral Service Licen Danielle Ward M01403 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicish. Mone disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner osquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 20412 Due to (or as a consequence of): Examine ohysician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ed by the a detached 1 9 Unknown 9 Unknown signed by d be detac Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Ures 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ٥ 1 Yes 2 1 No 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: I Director: After the funeral 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

<u>Archana Gupta, M.D</u>

onth, Day, Year)
JUL 0 5 2012

24035 Three Notch Road, Hollywood, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mønth Physician/ LeRoy Jackson Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Allegany Western MD Regional Med Ctr Cumberland If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) Months 64 218-50-0761 **Director** 1 ₺ M 2 🗆 F Aug 31,1947 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits with the Maryland ms 23a or 28a-f shorms must be notified at 10a. State 10c. City, Town or Location Director MD 1XXYes 2 □ No Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 1213 Braddock Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Was Decedon Armed Forces? 1 ☐ Yes 2 🗓 No the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Amusement park pest control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ျ (Rank) LeLand Douglas Jackson Miriam Elgie traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1213 Braddock Rd., Cumberland, MD 21502 Miriam E. Jackson / mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/30/2012 Luke's Cemetery Cumberland, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition Medical resulting in death) (or as a consequence of): Examiner ardiogeni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a. Was an cate has page 2 s Yes 2 this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No ျ ER/Outpatient 3 DOA 1 📈 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural Accident 5 Pending injury Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar

Q

29a. Certifie

(Check only one) 29b. Signature and title of

Medical

12500 Willowbrook Road, Cumberland, MD 21502 Ardalan Enkeshafi, 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

12-04483

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Terry Jackson 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 13, 2012 2230 hrs **Medical Examiner** Terry Lawrence Jackson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico 34628 Main Street Pittsville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Director Country) 6/2/1951 MD 1 X M 2 F 61 Yrs 215-58**-**5178 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location A 1 Yes 2 No 28a-f show Pittsville l other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Wicomico Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 bours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21850 34628 Main St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes 2 X No 1 Yes 2 No specify: white 4 X Divorced If Yes, Give Year Specify: <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wicomico County County Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Marcella R. Jones Lawrence R. Jackson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3928 Doe Run Dr., Salisbury, MD 21804 Robert Marvel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place 1 Number 2 Cremation 3 Removal from State 6/25/12 Pittsville, MD Pittsville Cem. 4 Donation 5 Other Specify. 21. Sign sure of Funeral Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval tt I. Enter the disease, or co Physician Part I. Enter the disease, or complication failure. List only one cause on each line Between Onset and Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus, obesity Completed After this certificate has been s uneral director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' 2 No Yes 2 ✔ No Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗸 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 V Natural 1 Yes 2 No 5 Pending in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. June 14, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 DNIO Zabiullah Ali, M.D.

State Registrar

31. Date filed (Month, Day, Year) 32. Redistrar's Signature 6 2012

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 6:11P M 2012 Kenneth Lee Klinger June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 45149 Nalley Road Hollywood Mary's Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days (Month, Day, Year) **Director** 1 👿 M 2 🗆 F 199-32-8735 69 Yrs 05/02/1943 Sunbury, PA Usual Residence of Decede or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits at 10a. State Director notified 1 🗌 Yes 2 🗓 No MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 45149 Nalley Road 20636 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, d Mental Hygiene. marked other than "natural", or iten matic event, the Medical Examiner r Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Crane Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file of Health and Mental Fitem 27 is marked or ပ္ Kenneth Henry Klinger June Fecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid Hershey / Wife 45149 Nalley Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Brinsfield-Echols Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/02/2012 Charlotte Hall, MD Funeral Service License 22. Name and Address of Facility $Brinsfield-Echols\ F.H.,\ P.A.$ 0 #M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC Onset and Death TROSIATE Ph, sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions the enneal position is as so) of sellcause. Enter Underlying Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of): Ŵ resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death detached 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has page 2 autopsy perform Hospital or Attending Physician: The After this certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural Natural 5 Pending Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F only one) 29b. Signature and title of 29d. Date signed (Month. Day. Year) 68846 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL. 25500 POINT LOUKEUT Rd. LEENARDTOWN MARY'S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Donna Carol Karmolinski June 22, 2:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mount Airy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days Hours (Month, Day, Year, 28, 1 73 Maryland Director 214-36-9545 1939 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Maryland Frederick Ijamsville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3325 Lowell Lane 21754 U.S.A. items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or Completed by 1 Never Married 2 Married and 2 should be filed within 72 hours after ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural", Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Jacob Mullin Lillian Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 1309 Butterfly Lane, Frederick, Maryland 21203 Wanda Hammond - Care Giver or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorium 6/26/12 Alexandria, Virginia 21. Signature of Full eral Service Ligansee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home over 26401 Ridge Road, Damascus, Maryla de of dying, such as cardiac or respiratory arrest, 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Pars Medical resulting in death) Due to (or as a consequer **Examiner** ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the l IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months?

1 Yes 2 XNo

9 Unknown Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Records, P.O. Fart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown to the runeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe e Hospital or Attending Physician: 1 24 hours after death. e Funeral Director: After this certifics Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? Investigation 2 🗌 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my action death. Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar Ira

Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

25

516

32

June 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucille Jean Van Kirk 6:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical Center Salisburu Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) Min. 136-14-0896 91 Director 1 🗆 M 2 🔀 F 06/20/1920 Delaware Usual Residence of Dece or than "natural", or items 23a or 28a-f show the Medicel Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21804 USA 1110 Healthway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health end Mental Hyglene. ant: if Item 27 is marked other that ury or other traumatic event, the N Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Dumont Louise Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Yorkshire Court, Fruitland, MD 21826 Susan J. Tucker/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any Injury or 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD 6/18/2012 . Signature of Funeral Service Deensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kull K 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AUVHIL disease or condition resulting in death) MEGLYSM Medical Due to (or as a consequence of): Êxaminer ASW! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate hes been signed by the attending physicien and page 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate hes autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 1 No 뎯 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe Nyta 347094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY MD 21504 Vel NATESAN 1415 S. DIVISION Sheet 31. Date filed (Month, Day, 32. Reg strar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8, per fh, 8929 7-13-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ \mathbf{A}^{M} 2012 2:01 MAY ANDREW JONATHAN KUEN JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WALTER REED NATIONAL MEDICAL CENTER BETHESDA 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 D F Social Security Number Min. **Funeral** Months Days Hours 5/25/2012 866-32-3951 Maryland Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location Director Alexandria 1 X Yes 2 No VA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22312 Funeral 6421 Cherokee Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 0 Be 18. Mother's Name (First, Middle, Maiden Syrname)
Lauren E. Patranella 17. Father's Name (First, Middle, Last) မ Andrew Jonathan Kuen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6421 Cherokee Ct. Alexandria, VA 22312 19a. Informant's Name/Relationship (Type, Print) 6421 Cherokee Ct. Alexandria, Andrew Kuen/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 6/8/12 Arlington, 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Murphy FH 4510 Wilson Blvd Arl., VA ture of Fineral Tervice Licensee 22203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EXTREME PREMATURITY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death , the the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed plnods been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy cate has l performed 1 ☐ Yes 2 ☐ No Yes 2 X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, å Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 XNatural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VA 0101237198 MAY 30 2012 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER HUDSON, BETHESDA, MD 20889 KERRY A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2012 parks Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Janice Marie Lohman June 24, 2:20 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Hours Director 578-48-0956 Usual Residence of Dece 1 □ M 2 **X** F 76 03/05/1936 Virginia 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location must be notified at Director MD 1 X Yes 2 No Calvert Chesapeake Beach 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 4025 Seagate Square 20732 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 ☐ Yes 2 🏋 No If Yes, Give by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 nan "natural", c 1 ☐ Yes 2 X No Specify Specify: 3 K Widowed 4 □ Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) event, the homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Ed Bell other traumatic Dorothy Virginia Shively 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health an Important: If item 27 is any injury or are 4025 Seagate Square, Chesapeake Beach, MD Lori L. Degollado, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/25/2012 Alexandria, VA Signalut of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, Harmony Lane, Owings, MD 23a. Part 1. Enter the disease aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that Approximate shock, or heart failure. st only one cause on Interval Between Onset and Death Immediate Cause (Final. Physician disease or condition resulting in death) Medical **Examiner** cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 the attending pl IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at I Director: After the din by the funeral Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending hours after death. 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed Month, Day, Year

Registrar

DHMH 17 Rev 06-2011

State

JRW)

#305, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Manoj Mathur, M.D., 110 Hospital Rd.,

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{Yea} June 11:20 Lassiter 24. Alice Rao Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 17212 Blossom View Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Davs Hours Country) 103-36-1332 65 Director July 18, 1946 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matrical and once. 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No 01ney Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20832 USA 17212 Blossom View Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Celestina Gagliardo Joseph Rao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17212 Blossom View Drive, Olney, MD 20832 David Lassiter/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 29, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2012 Signature of Funeral Service Licenses Francis J. Collins Funeral Home MD 20901 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause or Onset and Death Immediate Cause (Final bacteremia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner and neutro throm bocy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician metastativ Physician/Medical islet tell Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstruction Small bowel 1 Yes 2 No 3 Probably 4 Unknown severe gastroparesis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ¥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 Pending injury Natural
Accident
Suice Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely the within 2 29b. Signature and title of certifier an mehn 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Divi, Rockville, Moryhal 20850 mohammal Min mood, Do

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN

26

2013

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ASSITCK,

Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | | Please | Type or Pri | | | | | | - | | _ | ble. | | |
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| | | For State | | State of M | ate of Maryland / Department of Health and Mental Hygiene 2012 222 | | | | | | | | | | |
| | | Registrar | ne (First, Middle, Las | ct) | | | Certificate of | Deati | h | Tab. (6 | Reg. N | lo. | | | |
| Physicia Medi | | Madis | MU MINIGORE, EAS | Glu: | SIA | | Amp | | | 2. Date of De Month | eath 2^{D} | 7 20 | Year | 3. Time of Death | |
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| Funeral Director | _ | 5. Social Security N 215–34– | 4558 | ek 7. Ag XIM 2 □ F | e (In) rrs. Ia 78 | ast birthda Yrs | Months Days | | der 24 Hrs. s Min. | 8. Date of Bi (Month, Da 01/01/ | av. Year) | | g. Birthpla Countr Mary | | |
| and show at | ٦ | Usual Residence | 10b. County | | 10c. Cit | y, Town o | Location | | | | | | 10 | d. Inside City Limits | |
| Maryla 28a-f | rect | MD | Allega | ny | Cu | ımber | land | | | | | | | 1 X Yes 2 No | |
| th the | Funeral Director | 10e. Street and Nur | | . 010 | | | 10f. Zip Code | | | | 10g. C | Citizen of Wi | | ry? | |
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| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | b | | ried 2 Married | Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates. | | | Was Decedent of If Yes, specify Cult Yes 2 X N | | | Rican, etc.) | | | , White, et | c. | |
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| 2 shou th and 7 is m traum | | | ame/Relationship (7) | | | | ailing Address (Stree | | | | | | | · · | |
| l and if Healt item 2 | | 20a. Method of Disp | | / Sister | 20b. P | lace of Di | 912 Craddo sposition (Name of | | toad, | S.W., C | | erland | | | |
| t. Page 1 tment of rtant: If i | | 4 Donation | 5 Other (Specia | | C | emetery, (| y's Cemete | ery | 1 | 0/2012 | (| Cumbei | rland | , MD | |
| permi Depar Impor any ir | | Uro | neral Service Licens | Lesche | uc) | | 22. Name and Addr | ene 5 | t., (| umberla | ina, | ral Ho | ome, 21502 | P.A. | |
| Physician/ Medical | | 23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death) | art f la flure. List only o (Final | plications that caused ne cause on each line. Due to (or as | ∋. | | | ng, such | as cardiac | or respiratory a | rrest, | | | Approximate Interval Between Onset and Death | |
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| e executed sian and urial-transit | al Examiner | cause. Enter Unde Cause (Disease or that initiated event resulting in death) | injury is | C. Due to (or as | a consequ | ence of): | | | | | | | | | |
| ificate being physicias the bu | Medica | | _ | d | | | | | | | | | | | |
| ath cert attendir for use | Physician/Medica | IF FEMALE: 23b. Was decedent in the past 12: 1 ☐ Yes 2 ☐ 9 ☐ Unknown | months? | 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown | 2 Feta | I death | 3 | ncy | | | | 23d. Date Mont | | y Day Year | |
| requires that the des been signed by the s should be detached | by | 23e. Did tobacco use contribute to the | | | | | | | | | | cause of death? | | | |
| requir been s should | Completed | | | - | | | · · · · · · · · · · · · · · · · · · · | | | 24a. Was | | _ | | sy findings available | |
| ne law e has age 2 | dwo | | | | | | | | | auto perfe | psy ormed | pri de | or to com ath? | pletion of cause of | |
| sician: The law I certificate has t lirector, page 2 s | Be C | 25. Was case referre | ed to medical | | | | 26. 1 | Place of D | Death (Chec | l 1 ∐ Yes k only one) | 2 | No] 1L | Yes 2 | . □ No | |
| Physician: T this certifica ral director, p | 은 | 1 🗆 Yes 2 | | Hospital: | ent 2 🗌 | | tient 3 L DOA | her: 4 \square | Nursing Ho | ome 5 🗌 Resi | dence | 6 Other | (Specify) | | |
| or Attending Physician: fter death. Director: After this certific in by the funeral director, | Certificate: | 27. Manner of Deatl | 5 Pending Investigation | | | 28b. Tim- injui | y wo | | □No | 28d. Describe | how inju | ry occurred | | | |
| | | 3 ☐ Suicide 4 ☐ Homicide | 6 U Could not b determined | 28e. Place of Injubulding, etc | | | street, factory, office | | | 28f. Location (City or Tov | | | or Rural F | oute Number, | |
| the Hospital hin 24 hours : the Funeral I mpletely filled | Medical | (Check 2 | 🖳 Medical Exami | sician: To the best of ner: On the basis of e se Practitioner: To the | xaminatior | and/or in | vestigation, in my opir | ion, death | occurred a | t the time, date a | and place | e, and due to | o the caus | e(s) and manner stated | |
| Northi Con | | 29b. Signature and | title of certifier | | | | 29c. Licen | se numbe | | | | ate signed (| | | |
| To 11 | | 30. Name and add | ess of person who d | completed cause of d | eath (Item) | 23a (Typ | e, Print) | 2- | 11. | | 11 | 1 | ンノク | 87 | |
| Y/AUS | • | 31. Date filed (Mbb) | L)ColSC | 18U(| or's Sinda | 116 | VISOT | 1)a | 141 | more | N | Do | 41 8 | 0/ | |
| Sta | | J. Date med (MJU | M & D ZUIZ | Le Registra | ar's Signat | ure Co | Wille | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 pay 2012 June 4:45 P M Doris McKinnev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dayton Glen Hill Assisted Living Howard Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min 109-14-3122 Director 1 M 2 F New York Dec 11, 1915 96 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 14269 Triadelphia Mill Road 21036 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ▼Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jennie M. Nathaniel M. Lowery Bruce injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8332J Montgomery Run Rd Ellicott City, MD 21043 Marilyn M. Cole/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 6/30/2012 Valhalla, New York 4 Donation 5 Other (Specify) Kensico Cemetery 22. Name and Address of Facilit Harry H. Witzke's Family FH, Inc. 21. Signatur of Funeral Service License 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy the funeral director, Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: 5 Pending X Natural 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building_etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 7012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 Cedar Lane #103 Columbia, Maryland 21044 Andrew Lazris, M.D.

State Registrar 31. Date filed (Month, Day, Year,

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 2012 Mary Elizabeth Mohr 03:45 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Casey House Hospice Montgomery If Under 1 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days Months Hours (Month, Day, Year) Director 578-42-7605 1 M 2 F Yrs Aug. 31,1931 Massachusetts 80 Usual Residence of Decedent 28e-f ehow in then "neturel", or items 23e or 28e-f eho 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Olney ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours efter death with United States 20832 17605 Prince Edward Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?,

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education 4 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မှ Mary Elizabeth Lawrence 1 end 2 should by If Health and Mer item 27 is mark Henry Herbertson McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17605 Prince Edward Dr., Olney, MD 20832 Ralph P. Mohr/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 of begardment of blumportent: if its eny injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/2012 Metropolitan Crem. Alexandria, VA 21. Signature of Fyneral Septice Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home No P.O. Box 5038. Lavtonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary atherosclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sicien end burlel-transit Examir Due to (or as a consequence of): ettending physicien I for use es the burle Physician/Medical The lew requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown cate has been signed by the page 2 should be deteched 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? To the Hospitel or Attending Physicien: The within 24 hours after death.

To the Funerel Director. After this certificate? completely filled in by the funeral director, peg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify) HOSDICE 1 🗌 Yes 2 🔯 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 St Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) June 24, 2012 D 37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr., #100, Rockville, MD 20850 10 Geoffrey Coleman, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Sid State **JUN 26** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Physician/ :05 AM PHTLIP RAY MAHAN 06 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury
If Under 1 Year If Under 24 Hrs. Wicomico the Lake Hospice at 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Numbe 8. Date of Birth (Month, Day, Year) **Funeral** Country) 216-30-4092 82 1 XM 2 □ F Director April 6, 1930 Maryland Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 No Crisfield Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ed other than "natural", or items 23a or event, the Medical Examiner must be revent, Funeral 3228 Lawsonia Road 21817 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1954-Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify If Yes, Give 1957 3 Widowed 4 X Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or near မ Chloa Kreeger Walter K. Mahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 1101 - Allen, MD 21810 Kathy M. Johnson (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Beechwood Cemetery 6/25/2012 Princess Anne, MD Signature of Funeration Licensee

Mary Beth Bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition SCL/RY) DELWA, SYSTRWIC Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) been signed by the a should be detached it Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) director. To Be examiner? Other: 4 \square Nursing Home 5 \square Residence Characteristics Appearing Home 5 \square Residence HOSPICIE 1 Inpatient 2 ER/Outpatient 3 IDOA uneral 28c. Injury at work? 1 🗌 Yes 2 🗍 No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural
Accident
Suicide 5 Pending s af er death I Director: Aff Investigation the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 only one) 29b. Signature and title of certifier 058410

State Registrar offlicay

31. Date filed (Month, Day, Year)

SAUSTURY und

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 28 11:11 A M Leo Moyer John June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mary's 27219 Holly Lane Mechanicsville 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 230-11-1654 Yrs 48 <u>Vir</u>ginia 03/02/1964 Usual Residence of Deced ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 0a. State Director 1 Yes 2 X No St. Mary's Maryland Maryland Mechanics ville 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 USA 27219 Holly Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 5 þ 1 Never Married 2 X Married 1 ★ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify "natural", 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Government Contractor Facilities Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dinova Mary Ann Michael Yhe1ka and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 27219 Holly Lane, Mechanicsville, MD 20659 Louise B. Moyer/Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Lepartment of Important: If ite any injury . Page 1 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Mattingley-Gardiner 06/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, P.A. Crematory Leonardtown, MD Signature of Funeral Service Licensee Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on exc. line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to lor as a consequence of Cause (Disease or injury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has by page 2 s autopsy 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Director: After injury 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number HUU5575 on who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of p

Jennifer Schmidt

40900 Merchants Lane, Leonardtown, MD 20650

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5:00 A M 2012 Margaret Keenan Murray Ju1vMedical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte Hall 7520 Poplar Street Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 058-18-9949 **Director** 1 □ M 2 ី F 89 Yrs 05/25/1923 New York Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 Yes 2X No Charlotte Hall Marvland Charles 10g. Citizen of What Country? 10f. Zip Code ò 10e Street and Number Funeral items 23a USA 20622 7520 Poplar Street death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No ö þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Education 4 Teacher other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of ဂ္ Department of Health and Mont. Important: If item 27 is marked any injury or other. Margaret Dare Walter Keenan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Poplar Street, Charlotte Hall, MD 20622 <u>John Francis Murray/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Mary's Cemetery 107/05/2012 Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence cir. Exami and Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical that the death certificate be Box 68760 as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death signed by the a'd be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an page 2 s autopsy performe has certificate Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 4 Nursing Home 5 D Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA after death, Director: After this 27. Manner of De 11h 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

JUL 0

egistrar's Signatur

Physician/ -Month Morris Theodore Richard JNR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Civista 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Min (Month, Day, Year) 028-22-4987 **Director** 1 **X**M 2 □ F 82 10/07/1929 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location must be notified at Director 28a-f St. Mary's Hollywood Maryland ò Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 25080 Secretariate Drive 20636 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner ō ¥Yes 2 □ No þ 1 X Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Completed 3 Widowed 4 Divorced Specify: Morris, Richard Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineman U.S. Government injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ည Marcel Mierzejewski Vladislava Zajackowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or att Kristi Kay Baker/Stepdaughter 25080 Secretariate Dr., Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Mattingley-Gardiner 1 Burial 2 KCremation 3 Removal from State Home, P.A. Crematory 7/2/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility diner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the meant failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition Medical resulting in death) -aillure Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transi Due to (or nsequence of resulting in death) Last physician Physician/Medical certificate be Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 2 No. Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an has page 2 s autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pagn 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate:

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 🛭 📗

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 X No

Massachusetts

White

Interval Between

Onset and Death

Char

Black, White, etc.

Month

death?

24b. Were autopsy findings available prior to completion of cause of

28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inyestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. dertifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Medical

1 Natural

4 Homicide

29a. Certifier (Check

29b. Signature ar

31. Date filed (Month, Day, Year)

Accident

Suicide

5 Pending

of certifier

Investigation 6 Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July <u>Florant Otto Moran</u> 3. 2012 6:08 p.nM. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 356-20-3451 **Director** 84 1 🕱 M 2 🗆 F 10/22/1927 Illinois 28a-f show at Director 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits notified MD St. Mary's Hollywood 1 Tes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral with 45046 Irvin Street 20636 United States . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant! fitem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ☒ Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic 8 Automobile Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alphonsus Benjamin Moran Helena Marie Hemrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Moran (Son) 44921 Hickory Landing Way, Hollywood, MD 20636 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 07/05/2012 | Charlotte Hall, MD Signature of Funeral Service Licens

Danielle Ward M01403 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year been signed by the a should be detached t 2 🗌 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) H889 ce 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Investigation 1 Yes 2 No Accident 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature MD D42597 ess of person who completed cause of death (Item 23a) (Type, Print)

GRIML State

DHMH 17 Rev 06-2011

Registrar

<u>Jeffrey C</u>

Brown,

26840 Point Lookout Road, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23^{Day} Physician/ Tressia R. McGuire June 2012 7:26 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie Bowie Health Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 69 **Director** 232-68-8060 1 □ M 2 X F Aug. 14, 1942|West Virginia ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10c, City, Town or Location Director X□ Yes 2 □ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. Funeral 20715 12003 Whitehall Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married "natural", or 9 1 Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working University of MD permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College Park <u>Administra</u>tive Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Mays Robert Eugene Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20715 12003 Whitehall Drive, Bowie, Michael M. McGuire Sr., Hus. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Valley Head Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 N Removal from State 6-29-2012 Valley Head, WV nation 5 Other (Specify) f Fur eral Service Licensee 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of for use as the burial-trans and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stage Renal Disease, Dialysis 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes mellitus, type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Medical Certificate: 28d. Describe how injury occurred Natural iniury 5 \square Pending Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year, 2012 who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar
DHMH 17 Rev 06-2011

State

TaVI
31. Date filed (Month

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mD

Defense Hmy, #103, (ROFTON, MD 2 1114

| lease | Type of Print in Black Indelible ink. En | sure All Copies Are Leç |
|-------|--|-------------------------|
| | State of Maryland / Department of Health | n and Mental Hygiene |

| | 1- For State Registrar | | | Cert | ificate of | Death | | | Reg | g. No. | 20 | 15 555 | |
|--|---|------------------------------------|----------------------------|--------------------------|-------------------|---------------------------------------|---------------------|--------------|--|-------------|----------------------|--|--|
| Physician/ | | (First, Middle,Las | | | | | | | Date of Death Month | Day | Year | 3. Time of Death 1746 hrs | |
| Medical Examine | 4a. Facility Name (if | VERA | | McCOY-ES | | b. City, Town, o | r Location o | | luly 3, 201 | | ounty of Dea | | |
| | Holy Cross H | | | | | Silver Sprin | | | | | ntgomery | | |
| Funeral | 5. Social Security Nu | ımber 6. Se | × | 7. Age (In yrs. las | st birthday) | If Under 1 Yea | _ | _ | B. Date of Birth | n(MM/DD/ | | Birthplace (State or | |
| Director | 227-58-12 | 240 1□ | M 2XF | 67 | Yrs. | Months Day | ys Hours | Min. | AUG. 1 | 3, 19 | | eign Country)VIRGINIA | |
| _ | Usual Residence of I | Decedent | | Lo ou a | | | | | | | | Land traids On Line | |
| и апу | | 0b. County | | 10c. City, 1 | Town or Location | | | | | | | 10d. Inside City Limits 1 X Yes 2 No | |
| Aaryland 28a-f shnw Latonce | MD .] | PRINCE G | EORGES | | HYA | TTSVILL | E | | 1 10 | a Citizen | of What Co | | |
| the Maryland or 28a-f sh iffied at one | O / FO F | | EDD #7 | 1./ | | | 700 | | | | | • | |
| | | TOLEDO T | *** | 14 edent Ever in U.S | . 13. Was | ZU Decedent of Hi | 782 ispanic Orig | in? (Speci | fy Yes or No- | | J.S.A. Race - Ame | erican Indian, Black, | |
| r death with ur items 23 must be no | 1 Never Married | d 2 Married | Armed Fo | orces? | If Ye | es, specify Cuba | ın, Mexican, | Puerto Ric | an, etc.) | | White, etc. | | |
| s after or rall', m | 3 Widowed | | If Yes, Give Yee or Dates: | 1984–19 | | Yes 2 X No | | | | | | BLACK | |
| 5-0036 led within 72 hours at trygiene. other than "natural the Medical Examin Completed by | 15. Decedent's Edu | | | | | 's Usual Occupa st of working life | | | | 16b. Kind | of Business | s/Industry | |
| 5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed | Elementary/Secon | idary (0-12) | College (1 | -4 or 5+) | ADMIN | ISTRATI | 77F ACC | r m | | TIMIT | CVEDCI | ITY OF MD. | |
| d with distinct ther t | 17. Father's Name (F | irst, Middle, Last | 4 | | ADMIN | ISIKAII | | | rst, Middle, M | | | .11 OF FID. | |
| 21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica | | EORGE | RUFF | IN | McCOY | | | ROS | ANA | НС | OLLOMA | AN | |
| | 19a. Informant's Nam | ne/Relationship (T | ype, Print) | | 19b. Mailing | Address (Stre | et and Numi | ber or Rura | al Route Numb | per, City o | r Town, Sta | ite, Zip Code) | |
| and 2 should and 2 should feath and Me tem 27 is ma traumatic ev | ARIANNI 20a. Method of Dispo | E M. WAN | DELL/DA | | | LEY RD. | | | EBRATIO | | | 4747 or Town, State | |
| ore, es la of He of He If ite | | Cremation 3 | Removal fr | | ematory or oth | | sinetery, | | ate | 200. L006 | auon - Ony C | or rown, state | |
| Baltimore, permit. Pages la Department of He important: If ite | | Other Specify | | CHA | MBERS | CREMATO | RY Section | 7-7- | 2012 | RIV | /ERDAI | LE, MD. | |
| Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum | 21. Signature of Fund | Plu Mu | leas 1 al | ₽ M000 | CH | AMBERS | FUNERA | AL HO | ME & CI | REMAT | CORIUM | 1,P.A. | |
| Physician | 23a. Part I. Enter the | | | | | O1 CLEV e mode of dying | | | | | | Approximate Interval | |
| Medical | failure. List only | one cause on ea inal disease a. | | phic La | teral S | clerosi | S | | | | | Between Onset and Death | |
| Examiner | or condition resulting | | | consequence of) | | | | | | | | | |
| | Sequentially list cond | | Due to (or as a | consequence of): | | | | | | | | | |
| Insit | cause. Enter Underl | lying Cause | | | | | | | | | | 51 | |
| cuted and transit | events resulting in de | eath) Last | Due to (or as a | consequence of) | | | | | | | | | |
| 760, cate be executed physician and the burial - transi | X UNPENDED | d. | AMENDED 2 | 3a,27,pe | er me.g | 930 8-1 | 4 - 12 s | sm | - | | | | |
| 760, icate be execut physician and the burial - tra | IF FEMALE: | | | outcome of pregna | | | | | | 23d. Da | ate of delive | ery | |
| 587 ertifica ling pl | | | 1 Live b | irth | 2 Feta | al death 3 | Ectopic | pregnancy | | Moi | nth | Day Year | |
| the death certification by the attending the death of the attending the death of the as as Physician. | 1 Yes 2 ✔ No | | | ant at time of dea | th 5 Oth | er (Specify) | | | | ì | | | |
| P.O. B ithat the danged by the detached is detached by the by the by the by the by Phy | Part II. Other signifi | cant conditions | | | sulting in the ur | nderlying cause | given in Par | rt I. | 23e. Did tob | acco use | contribute t | to the cause of death? | |
| P.C. res that signed be deta | | | | | | | | | 1 Yes | 2 🗸 No | 3 Pr | obably 4 Unknown | |
| rds, requir | | | | | | | | | 24a. Was ar | | | autopsy findings available completion of cause of | |
| Records, i. The law requires fitcate has been significate by page 2 should be Completed | | | | | | | | | perform | ned? | death? | _ | |
| Division of Vital Records, P.O. ta or Attending Physician: The law requires that the start cleath. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacentification: To Be Completed by F | | ed to medical | | | | 26.Plac | e of Death (| Check only | | | | | |
| f Vital Physician er this certi ral directo | examiner? | □ No | Hospital∷ 1 | npatient 2 🗸 E | ER/Outpatient | 3 DOA | Other ₄ | Nursing H | ome 5 R | Residence | 6 Oth | er: | |
| ing Pl | 27. Manner of Death 1 X Natural | | 28a, Date (Month | of Injury , Day,Year) | 28b. Time of In | | ury at Work? | | d. Describe ho | ow injury o | ccurred | | |
| sion trend death. ctor: y the f | 2 Accident | 5 Pending Investigati | | | | | Yes 2 | | | | -43 | | |
| Division of Division of Spital or Attending Phours after death. Ineral Director: After if filled in by the funeral Certification: T | 3 Suicide 6 Could not be determined (Specify) | | | | | | | 281 | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| lospita hours unera unera Ly fille | | | (Open.y) | t of my knowledge | a death occur | ed at the time of | late and nia | ce and due | a to the cause | (s) and m | anner as st: | ated | |
| Division of Vital Records, P.O. Box 68: To the Bospital or Attending Physician: The law requires that the death certifice within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician | (Check only one) 2 | | r:On the basis | of examination and | | | | | | | | | |
| | 29b. Signature and ti | itle of certifier | and manner s | tated. | - | 29c. Licen: | se number | | | 29d. Date | signed (M | fonth, Day, Year) | |
| | familian. | thous m |) | | | O.C. | .M.E. | | | July 5, | 2012 | | |
| | 30. Name and address | ss of person who | | | • | | | | | | | | |
| | Pamela E. S | | | Medical Exam | | W. Baltimor | re Street, | Baltimo — | re, MD 21: | 223 | | | |
| State Registra | | L 09 20 | 2 2 | gistrar's Signatur | par | 2 | | | | | | | |
| ricgistia | | _ UU LU | 1 | and by | - (7) | | | | | | | | |

12-04695 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Bambi L. Mathews 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 22, 2012 Medical Examiner Bambi Lynn Mathews 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 9. Birthplace (State or 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director Country) MD 2 X F Feb 21, 1957 1 M 216-80-7092 55 Usual Residence of Decedent 10c. City, Town or Location 10b. County Cumberland Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tramanic event, the Modical Examiner must be notified at once. MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 221 E. Union Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes White Yes 2 No specify: 3 Widowed 4 X Divorced If Yes, Give Year Specify: ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nancy Lee (Keiley) Costabile Dominick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 441 Walnut St., Cumberland, MD 21502 Joseph L. Cunningham / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State partment inportant: Cumberland Crematory 6/24/2012 Cumberland, MD 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ns Family Funeral Home, P.A. Decatur Street, Cumberland, MD 21502 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complicate Physician failure. List only one cause on each line /Medical Septic shock Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Peritonitis Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause c. Perforated gastric and duodenal ulcers (2) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED e attending physician for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 🗸 Yes No

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: After this within 24 hours after death. To the Funeral Director: filled in by

the

27. Manner of Death

Suicide

Accident

Homicide 29a. Certifier 1 (Check only one) 2

29b. Signature and title of certifier

31. Date filed (Month, Day Y

1 V Natural

2065 State

Certification:

Medical

3

30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner

and manner stated.

Pending

Investigation

Could not be

determined

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

OCME

0910 hrs

10d. Inside City Limits

1 X Yes 2 No

Approximate Interval

Between Onset and

Death

Year

2 No

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City

June 23, 2012

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2012 $7:15 A^{M}$ July Norment Warren Leigh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 14746 Patuxent Avenue <u>Solomons</u> Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months 228-22-8830
Usual Residence of Decedent 1 🕱 M 2 🗆 F Director 85 Yrs. 09/02/1926 Virginia show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 X No 28a-f Mechanicsville Marvland | St. Marv's 10a. Citizen of What Country? ms 23a or must be n 10e Street and Number Funeral 20659 USA 29798 Allison Circle items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No Black White, etc. 0 þ 1 Never Married 2 Married 1 X Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 X Divorced "natural" Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Communications 12 Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Alice McGhee Alva Summerfield Norment 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linwood Norment/Son 29798 Allison Circle, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem: 07/13/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Sign vury of Funeral Service License M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of) resulting in death) Last Gastro intes Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Por Day 5 Other (specify) Pregnant at time of death the hed g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure 3 Probably 4 Unknown 2 🗌 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has the lirector, page 2 s autopsy perform death? ☐ Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer. Natural intury 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20650 MONIKA G ene 3130 HOakley Romandton 31. Date filed (Mont) State JUL 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 26, Day 2012 Year Physician/ 5:45 AM Neilson Μ. Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Harwood Mandarin House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, Year) Months Hours 577-38-6470 **Director** 1 M 2 K F Wash DC 82 June 3, 1930 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State at Director Examiner must be notified 1 Yes 2 X No Calvert Sunderland 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 20689 5651 Hardesty Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 0 ģ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Gov't Administrator marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I McFarland Catherine James A. Bowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .03 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 5651 Hardesty Road Sunderland, MD Otto Neilson / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 06/27/2012 Clinton, MD 4 Donation 5 Other (Specify) 8200 Jennifer Ln. 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Hry J. Goff Owings, MD 20736 Lee Funeral Home Calvert, PA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
WCEN 23a Part 1 shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ BSTRUCTION SMAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth Z
Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day Year the 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Funeral Director: After this certificate has stely filled in by the funeral director, page 2.3 autopsy perform 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ➤ No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26 D003658) 6 $M \Gamma$ MP

State Registrar

JRW 5

Eva Hersh,

1) a

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registra

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31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year June 21 10:55 Ethel Louisa Wood Nutwell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) 218-28-1656 Director 1 □ M 2 🗓 F Yrs. 93 07/24/1918 Maryland Usual Residence of Decedent 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits or 28a-f sl 1 Yes 2 No MD Anne Arundel Deale 10e. Street and Number 10f. Zip Code r must br 5 10g. Citizen of What Country? Funeral 5700 Swamp Circle Road 20751 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than "event, the Med Elementary/Secondary (0-12) nt of Health and Mental Hygiene.

If item 27 is marked other that or other traumatic event, the N College (1-4 or 5+) 12 <u>Homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Norwood Wood Sarah Ellen Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny L. Tasheuras, Niece 109 Stone Point Dr., Apt. 356, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) James' Cemetery 06-25-2012 Lothian, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final AORTIC Onset and Death VALVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): HEART DISEASE **Examiner** YEARS PERTENSIVE 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate by 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 X DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Freedsh

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD, SUITE

32. Registrar Signature

BESTGATE

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 12. 2012 3:00 A^{M} Joseph Nahan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Shady Grove Adventist Hospital</u> Rockville Montgomery Co. 7. Age (In vrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) Director 036-09-2390 1 M 2 D F 93 Yrs January 29, 1919 Rhode Island 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 No VA Fairfax Co Falls Church 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7606 Salem Road 22043 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any hiury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 res, Give Year or Dates. **1941-1961** 1 ☐ Yes 2 1 No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Management Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John B. Nahan Teresa Husseu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Nahan (wife) 7606 Salem Rd., Falls Church. VA 22043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State August 3,2012 4 ☐ Donation 5 ☐ Other (Specify) rlington National Cemetery Arlington. VA Sig e of Funeral ce licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046 Part 12 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy for Other (specify) Month Dav Pregnant at time of death 4 Pregnant : 1 ☐ Yes 2 ☐ Unknown detached by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖸 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No After this certificate director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 1 Natural Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred iniury 5 Pending 2 No Accident Suicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated twing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2

To the I only one To the 29b. Signatur 29d. Date signed (Month, Day, Year) 20+1 1700212514

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31. Date filed (Month, Day, Year)

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Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmot, MD 2401 Research Blief. Suite 330, Roderill, Maybre 20850

0850 28a-f show death with the Maryland 23a or or items 72 hours after Baltimore, Maryland 21215-0036 "natural" than " Page 1 and 2 should be filed within and Mental Hygiene. marked other S item 27 Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Francis Nolan ам 2012 8:00 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days (Month, Day, Year) Hours 217-36-5052 1 🕱 M 2 🗆 F Director 74 July 27, 1937 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Examiner must be notified 1 ☐ Yes 2X No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 4306 Joplin Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc by 1 Never Married 2 X Married Yes Yes, Gi Specify: White 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Refrigeration Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Bernard Aloysius Nolan Marie Bernadine Mealy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Teresa Nolan/Wife 4306 Joplin Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth Gate of Heaven Cemetery Cemetery June 29, 1

Burial 2

Cremation 3

Removal from State Silver Spring, MD 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph, i ian/ disease or condition resulting in death) Medical Due to (or as nsequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last inding physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death q Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗆 No After this certificate 1 Yes 2 25. Was case referred to medical examiner?

1 \(\subseteq \text{Yes} \) 2 \(\text{No} \) No Be 26. Place of Death (Check only one) Other: ပ 1 Nnpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 — Yes Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending death. Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 6/25/12 68658 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Cor Dr Rockville MD 20850 9901 Kinna (Month, Day, Year) State 27 2012 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elbert Nave Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lions Center for Rehab & Ext. Care Cumberland Allegany 8. Date of Birth (Month, Day, Year) 06/17/1922 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 210-12-3372 Director 1 💢 M 2 🗆 F 90 Pennsylvania show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Cumberland 1 X Yes 2 □ No MD Allegany 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? USA Funeral 21502 901 Seton Drive, ext. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status rmed Forces?

X Yes 2 \(\sum_{No} \) 1942-Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced 1945 White Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Co-Owner Service Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Nave DeVore Effie မ 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 14301 Hazen Road, NE, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Susan N. Shaw / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Union Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 06/25/2012 Centerville, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Se 404 Decatur Street, Cumberland, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CHRUNIC OBSTRUCTIVE LUNG DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 12 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

+ State

0

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

02690

Walsh Rd. Comberland

29d. Date signed (Month, Day, Year)

TUNE 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year 5:57 PM 2012 Vincent Portanova Tune Medical Rocco 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Briar Meadow Assisted Living Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) NY 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min. XXM 2 F Hours Matteth ^D1/2^{*}; 1925 87 118-22-1111 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 7317 Centennial Road **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. White Specify: 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give WWII Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Public Relations Director Sport Conglomerate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delfico ပ Joseph Portanova and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7317 Centennial Road, Derwood, MD 20855 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Elizabeth C. Portanova/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 26, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2012 Atlantic Crematory Glen Burnie, MD Cole Funeral Services, #PoA; Rockville, MD 20853 Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of Examine Hypertensive Heart Disease Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Coronary Heart Disease that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Dementia Box 68760 nding physuse as the l use as IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery atten for us in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ed by the g Unknown 9 Unknown P.0. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Group Home 6 XI Other (Specify) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47330 June 25, 2012 17W WUMUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 50 W. Edmonston Drive, Rockville, MD 20852 Thomas V. Joseph, MD 31. Date filed (Month, Day, Year) **JUN 27** Registrar's Signature, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SARA LOUISE PRICE 3013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death astor Memorial lalbot Hospital at Easton Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Hours Country) 221-10-5471 91 Director 1 □ M 2 X F 9/19/1920 MARYLAND Usual Residence of Decedent ir then "neturel", or Items 23e or 28a-f show the Medical Exerciner must be notified at 10a State 10c. City, Town or Location Director 10d. Inside City Limits MD TALBOT TRAPPE 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? **Funeral** 29160 KRISMOR COURT, RAYLAND ACRES 21673 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pege 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neture!", or it eny lipity or other treumetic event, the Mental once. Black, White, etc. ģ 1 Never Married 2 Married アレルモ・コストル Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 0 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAGGIE LAFFERTY WILLIAM DUDLEY MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERI L. BURTON, NIECE 1701 BRANNOCKS NECK ROAD, CAMBRIDGE, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 6/21/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FEL. 200 Name and Address of Facility
LLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
O SOUTH HARRISON STREET EASTON, MD 21601 MERC EASTON, MD Jana 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Uxinary Tract disease or condition resulting in death) Medical Due to (or as a conte uence of): Examiner ration Sequentially list conditions. ll any, leading to intrisdicts cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physicien: The lew requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physicien: The lew requires that the death certificate be ex within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien completely filled in by the funeral director, page 2 should be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia - Advanced 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Prijociation in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD D006956 Than 06,19,2012 125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 RAVI MOHAN, MD 219 SOUTH WASHINGTON STREET, EASTON, MD 21601 31. Date filed (Month, Day, Year) State Registrar's Signature JUN 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ona Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arunde Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 331-14-6723 Director 1 □ M 2 🔽 F 91 25, 1921 Illinois 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d, Inside City Limits Director 1 X Yes 2 No Bowie MD Prince George's 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 20715 3505 Mase Lane items 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1Å Yes 2 □ No If Yes, Give Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exar Specify: White Completed 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Federal Civil Service Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file h and Mental F 7 is marked of ၉ Leo C. Schroll Augusta Malensky 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Mase Lane, Bowie, MD 20715 Michael Pirato - son 20a. Method of Disposition 20b. Place of Disposition (Name of centietery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 6-23-2012 Metro Crematory Baltimore, MD 22. Name and Address of Facility Beall Funeral Home of Fineral Service Licens 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) weelt Medical Due to (or as a Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death for in the past 12 months Day Month Year Pregnant at time of death 2 110 Yes Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed d be de 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 4 မှ 1 Chipatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this uneral Director: After the form by filled in by the form Manner of D Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) ural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person 2115

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 24. 2012 Allan Paterson 8:59 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice Casey House 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 095-44-8705 Director 73 Nov. 2, 1938 West Indies Usual Residence of Deceder r than "natural", or items 23a or 28a-f show the Medical Examins: must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State West Director 1 Yes 2 No Grenada Indies 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Hope St. Andrews Grenada 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pege 1 and 2 should be filed within 72 ment of Health end Mental Hygiene. ent: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bridgette Anthony Patrick Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope St. Andrews, Grenada, West Indies (Wife) Winona Paterson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pege 1 and Department of F 1 X Burial 2 Cremation 3 Removal from State Important Gram Bras Cemetery 7/16/2012 St. Andrews, Grenada injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livense ²² Name and Address of Faculty Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Gastric Carcinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) 2X No ဨ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) cal 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0060634

6001 Muncaster Mill Rd., Rockville, MD 20855

June 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1000 P M July 2012 Quade Aloysius Francis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 22700 Maddox Road Bushwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs, last birthday) Min. Hours 213-40-9985 1 🗶 M 2 🗆 F Yrs 70 Maryland 12/17/1941 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No St. Mary's Bushwood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 20618 22700 Maddox Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Planner

20b. Place of Disposition (Name of cemetery, crematory or other place,

Calvert Cliffs

Lacey

20c. Location - City or Town, State

July 5, 2012

18. Mother's Name (First, Middle, Maiden Surname)

Irene

Grace

22700 Maddox Road, Bushwood, MD 20618

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Nuclear Power Plant

filed within 72 hours after death with the Maryland notified ms 23a or "natural", or ite Baltimore, Maryland 21215-0036 ntal Hygiene. ed other than " event, the Mex permit. Page 1 and 2 should be filed Department of Health and Mental Hy Inportant: If item 27 is marked oth any injury or other traumatic event one. For State Registrar

10a. State

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Virginia E. Quade/Wife

Carrol1

1 X Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarah A. Johnson, M.D.

31. Date filed (Month Y)

12

James

20a. Method of Disposition

College (1-4 or 5+)

Quade, Sr.

Director

Funeral

þ

Completed

Be

ည

Physician/

Medical

Examiner

Funeral

Director

28a-f

Physician, Medical Examiner Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed and n 24 hours after death.

Re Funeral Director: After the bletely filled in by the funeral

Division of Vital Records, P.O. Box 68760

Physician/Medical

þ

Completed

Medical Certificate: To Be

| 4 ☐ Donation 5 ☐ Other (Specify) | (| Charles Mem | orial Grd | 7/9/2013 | 2 | Leonardt | own, MD | | | |
|---|--|--|---|-----------------------|----------------------------|--------------------------|--|--|--|--|
| 21. Sweet re of Funeral Service bioenside | rdiner | 22. Nam Ma 41 | e and Address of Facili ttingley—G 590 Fenwic | ardiner l k St., L | Funera eonar | al Home, itown, Mi | P.A. 20650 | | | |
| 23a. Part . Enter the disease, or complica shock, or heart failure. List only one c Immediate Cause (Final disease or condition | ause on each line. | death. Do not enter the r | | | | | Approximate Interval Between Onset and Death | | | |
| resulting In death) | Due to (or as a con | | | | | | lyear | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as a consequence of): | | | | | | | | | |
| resulting in death) Last | Due to (or as a con | sequence of): | | | | | | | | |
| IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \) Unknown | If yes, outcome of pro 1 Live Birth 2 4 Pregnant at time 9 Unknown | Fetal death 3 Ecto | pic pregnancy r (spec <i>ify</i>) | | | 23d. Date of de Month | elivery Day Year | | | |
| Part II. Other significant conditions contri | ibuting to death but no | t resulting in the underly | ing cause given in Part | l. 23e | | | o the cause of death? Probably 4 V Unknown | | | |
| | | | | | . Was an autopsy performed | prior to death? | utopsy findings available completion of cause of s 2 \square | | | |
| 25. Was case referred to medical | | | 26. Place of Dea | ath (Check only one | 9) | | | | | |
| examiner? 1 Yes 2 No | pital: 1 Inpatient | 2 ER/Outpatient 3 | DOA Other: 4 🗆 N | ursing Home 5 | Residence | e 6 Other (Spec | cify) | | | |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation | 28a. Date of injury (Month, Day, Yea | 28b. Time of injury M | 28c. Injury at work? 1 Yes 2 No | | | njury occurred | | | | |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - / building, etc. (Sp | njury - At home, farm, street, factory, office 28f. Location (Street and Number or Fatc. (Specify) 28f. Location (Street and Number or Fatc. (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Street and Number or Fatch (Specify) 28f. Location (Spec | | | | | ıral Route Number, | | | |
| 29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner 3 Certifying Nurse P | : On the basis of examin | nation and/or investigation | n, in my opinion, death o | ccurred at the time, | date and pl | ace, and due to the | cause(s) and manner stated | | | |
| 29b. Signature and title of certifier | | | 29c. License number | | 29d. | Date signed (Mont | h, Day, Year) | | | |

D71807

40900 Merchants Lane, Leonardtown, MD 20650

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 June 7:22 Hazlette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Solomons Nursing Center Solomons Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 M 2 6 F 11/01/1916 Virginia 95 Yrs. Director 579-09-9833 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 W No Gambrills Marvland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21054 1032 Christmas Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed <u>White</u> 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Sophia Anne Howell Herman Arthur Rooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Christmas Lane, Gambrills, MD 21054 Linda A. Mathers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 06/26/2012 Alexandria, Virginia Metropolitan Crematory Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Onot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final et and Death Physician/ ongestive disease or condition resulting in death) Medical Due to (or as a consequence of Examiner toatro Ptenosis Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Vear Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the funeral director, page 2 autopsy perform Yes 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner's Other: 2 **N**No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dennett 14.0 D25156 June 26, 2012

State Registrar

Box 68760

P.O.

11845 H.G. Trueman Road, Lusby, MD 20657

backer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

Charles W. Bennett, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Medical Month 19 Doinsor .50 P M oral June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 29816 ustin AVENUE 42stan Talbot Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-40-1818 Director 80 1 X M 2 □ F 6/30/1931 WASHINGTON, DC Usual Residence of Decedent show 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director EASTON 1 X Yes 2 No MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 29816 DUSTIN AVENUE 21601 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 X Married X Yes 2 No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha FIELD ENGINEER COMPUTERS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JULIUS ROBINSON SADIE WOLFE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace once. 29816 DUSTIN AVENUE, EASTON, MD RICKA M. ROBINSON, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VA CEM. 6/25/2012 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 200 SOUTH HARRISON STREET, EASTON, MD 21601 JOHN R. MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final (transitional ancer bladder cel) Physician/ carcinoma) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Box 68760 as the attending IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed by 1 Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No Division of Vital the Hospital r Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No Other: ည 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director After 1 🗹 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Practitioner: To the best of my knowledge. Seath second of the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059939 06-20-2012 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDTVA Miles Piver Physicians 508 Idlewid Avenue Easton, MD 21601 32 Registrar's Signature State

Registrar
DHMH 17 Rev 06-2011

JUN 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G929 7/23/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ruffead, Jr. Arthur Harold 2012 11:25A M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 343-34-0639 246-04-7189 8 Date of Birth 9. Birthplace (State or Foreign Funeral Hours Months 71 Director Pennsylvania 4/28/1941 Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director notified 28a-f St. Mary's Hollywood 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? ms 23a or must be Funeral with t 20636 USA 44996 Blackistone Circle items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter dical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 😾 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Fire Protection Fire Protective Engineer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Halkowitz Arthur Ruffead, Sr. Harold traumatic and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Erin Ashley Ruffead/Daughter 8109 Summer Palm Court, Jacksonville, Fl 32256 other Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₹ Mattingley-Gardiner
Funeral Home, P.A. Crematory 1 Burial 2 X Cremation 3 Removal from State 7/5/2012 4 Donation 5 Other (Specify) Leonardtown, MD hat Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtwon, MD 20650 23â. Parv 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCT ZO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 7 YEARS OVZUVANA 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 the IF FEMALE: ISP 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes. 2 L 9 ☐ Unknown the page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à or Attending Physician: The law recuires Division of Vital Records, WYPERTENSZON 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of HYPERLIPZORMIA 24a. Was an has autopsy perform death? this certificate PENGETES 2 No Yes 200 N funeral director, 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 6 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check To the I within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) -0 h 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20610 Deme BRUCE ROBERT GERSON 25500 MO POTNY LUNGUIT ROAD LEONAND TUWN)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:304 M Physician/ Ramirez Abad 2012 sunt Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel **Examiner** 211 Scott Drive 5. Social Security Number 579–54–7600 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 79 Director 1 🛛 M 2 🗆 F Feb. 28, 1933 Peru and Mental Hygiene. 7 is marked other than "natural", or items 23e or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Annapolis Maryland Anne Arundel tXXYes 2 ☐ No 10g. Citizen of What Country?
U.S.A. 10e. Street and Number 10f. Zip Code 21401 Funeral 211 Scott Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Architecture Architect traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manuel Ramirez Tomasa Estrada ည and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Scott Drive Annapolis, Maryland Constance Ramirez/wife of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 🏖 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 6/26/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardioThRombotic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner cardiovaskular meros curonic Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of s certificate has build be continued in the contract of the co autopsy perform death? 1 Yes 2 🗌 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this c funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred After 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, inmy opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D 0 0 5 7465 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nsRyaparseMD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NS Rayapall St Mp 2835 Sm17 /W \$703

31. Date filed (Month, Day, Year)

JUN 2 6 2012

32. Registrar's Signature

State

Registrar

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rader Ralph Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sep 22.1943 215-44-7793 Director 1 🖰 M 2 🗆 F 68 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland notified MD 1 Yes 2 X No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 14319 Winchester Road SW 21502 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces 2

1 Yes 2 No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 🗆 Yes 2 🕍 No "natural", Specify: Completed 3 Widowed 4 Divorced white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the cable splicer Verizon traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ralph L. Rader, Sr. Mary Malcolm 19a. Informant's Name/Relationship (Type, Print)
Doris Rader Lybe 1 and 2 sincepartment of Health an.
Important; If item 27 is many injury or other 19b. Mailing Address (Street and Number or Funal Route Number, City or Town, State, Zip Code) 21502 wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 6/19/2011 LaVale MD ation 5 D Other (Specify) ianature neral Service 22. Name and Carpellif Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, of heart failure. List only one cause on each line. riplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 Yes 2 No 1 🗌 Yes 2 🖼 🕶 filled in by the funeral director, 25. Was case referred to medic 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 N N မ 1 Department 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 tural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check

6

To the

erson who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| | AME | ND | PI LINE C PE | Please T R MD G | vpe or State o | Print in 24712 f Maryla | Black II TRT and / Dep | <mark>ndeli</mark> artme | ble Inkent of H | c. Ensure lealth and | All Copi d Mental F | <mark>es A</mark> r Iygien | <mark>e Legi</mark> e | ble. | | |
|-------------------|--|----------------------|--|--------------------------|--|---|--|-----------------------------|-------------------------|--------------------------------|---|--|--------------------------|-----------|--|--------------|
| | | • | For State Registrar | | | | • | | te of E | | | Reg. No. 2012 22296 | | | | |
| | Discolate | | 1. Decedent's Name (First, | Middle, Last) | | | | | | | | 2. Date of Death _Month | | | | |
| | Physicia Medio | | Ermenegilda 1 | | | | | , | | | June | 26 | 20 | 12 12 | 1:45 | Рм |
| | Examin | er | 4a. Facility Name (if not ins | | reet and nun | nber) | | 1 | | Location of De | ath | | c. County o | | | |
| ~~ | Funeral | | 2100 Nona Fan 5. Social Security Number | m Koad 6. Sex | | 7. Age (In vrs | . last birthday) | | ince Fi der 1 Year | rederick If Under 24 F | Irs. 8. Date of | Calvert 8. Date of Birth 9. Birthplace (State or Foreign | | | | r Foreian |
| | Director | | 214-80-4250 Usual Residence of Deced | 1 🗆 | M 2 X F | 89 | | Month | s Days | Hours M | | | | | | |
| | and show | ō | | County | | 10c. (| City, Town or Lo | cation | | | | | | | 10d. Inside Ci | ty Limits |
| | Maryl 28a-f otifie | irec | Maryland Cal | vert | | Pr | rince Frederick | | | | | | _ | | 1 🗆 Yes | 2 🗓 No |
| | h the Saor ben | Funeral Director | 10e. Street and Number | | | | | 10f. 7 | Zip Code | • | | 1 | Citizen of What Country? | | | |
| | ms 2; must | ner | 2015 Nona Farm | | 2 Was Door | dent Ever in l | 10 10 | Was Das | 2067 | | (Specify Ves or N | | ted St | | and lasting | |
| 980 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Fi | 11. Marital Status 1 Never Married 2 3 V Widowed 4 D | ☐ Married | Armed Fo 1 Yes If Yes, Giv Year or Da | rces? 2 X No e X | ? If Yes, specify Cuban, Mexican, Puerto F | | | | | 10- | | , White, | | |
| 2-0 | hour natur dical | Sete | 15. [| Decedent's Edui | cation | | 16a. Dece | | | ation luring most of v | varking | 16b. | Kind of Bus | siness In | ndustry | |
| 21215-0036 | hin 72 ne. than " | mo; | Elementary/Seconday | - T | College (1 | | life. D | O NOT I | ise retired) | iuning most or v | VOIKIII | | \ TY | _ | | |
| 2 | ed with | Be C | 17. Father's Name (First, M. | fiddle Last) | 1 | | Ho | memal | œr | 18 Mother's I | Name (First, Midd | _ | wn Ham | | | |
| ano | be file ental I ked o c eve | 2 | Pietro Dreoss | . , | | | | | | | enturini | iie, ivialue | n oamanie) | | | |
| Maryland | and Me | | 19a. Informant's Name/Re | | e, Print) | | 19b. Maili | ng Addre | ess (Street a | and Number or | Rural Route Nun | ber, City | or Town, St | ate, Zip | Code) | |
| Ξ̈́ | id 2 st salth a n 27 is er tra | | Carla J. Thom | as / Daug | ghter | | 6421 I | Pound | Apple | Court, C | olumbia, l | ⁄aryla | ind 210 | 45 | | |
| Baltimore, | Page 1 an nent of He ant: If iten iry or oth | | 20a. Method of Disposition 1 ☐ Burial 2 | mation 3 🗆 R | emoval from | State | . Place of Dispo cemetery, crei | matory o | r other plac | | Date /28/2012 | | Location - (| - | | |
| alti | permit. Departn Imports any inju | | 21. Signature of Funeral S | | / | 1 | 2: | 2. Name | and Addres | ss of Facility | Rausch Fu | | | | | |
| ш | <u>205</u> | | ▶ Kyle S. Si | | | 12 | 7 | | | | oad, Port | | olic, M | aryla | and 206/6 |) |
| I, | | | 23a. Part 1. Enter the dise shock, or heart failur Immediate Cause (Final | | cause on ea | ch line. | | | | , | iac or respiratory | | | | Approximate Interval Bette Onset and [| ween |
| | Inysician/ Medical | | disease or condition resulting in death) | a. | Due to | or as a conse | equence of): | 17 | | | taiv | | | + | | |
| ang to | Examiner | , | Constant live float and stitling | | | 1 | legit | ı. | 79 | il un | ٤ | | | | | |
| | - # | ine | Sequentially list condition It can, reading to an accurate cause. Enter Underlying | to D | | ur as a ourse | | | | | | | | - 1 | | |
| | executed an and rial-transi | Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | C. | | or as a conse | ORONARY | AR | ERY I | DISEASE | | | | \dashv | | |
| 0 | be executed sician and burial-transit | calE | resulting in death, East | d | | 0. 40 4 00110 | | | | | | | | | | |
| 68760 | ficate be g physicias the bu | Medi | [<u></u> | _ 0 | | | | | | | | | | | | |
| Box 68 | Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 24 hours after death certificate has been signed by the attending physicial therents Districtor. After this certificate has been signed by the attending physiciated filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | allt 1 | 1 Live | come of preg Birth 2 For nant at time of nown | etal death 3 | Ectop Other | c pregnanc (specify) | - | | - | 23d. Date Mon | | | Y ear |
| P.O. | requires that the de been signed by the should be detached | by Pr | Part II. Other significant of | conditions conf | tributing to d | eath but not r | resulting in the | u nd erlyin | g cause giv | ven in Part I. | 23e. D | d tobacco | use contri | bute to t | he cause of d | eath? |
| dS, | puires en sigr uld be | ed t | | | | | | | | | _ 1 | Yes | 2 ×No | 3 🗌 Pro | bably 4 🗌 | Jnknown |
| of Vital Records, | as bee | Completed | f . | | | | | | | | 24a. W | as an itopsy | | | opsy findings a ompletion of c | |
| Re | The law cate has page 2 s | Son | | | | | | | | | | erformed? | | eath? | 2 🗌 No | |
| tal | sician: The certificate rector, pag | Be | 25. Was case referred to mexaminer? | - | ospital: | | | | | ace of Death (C | | - Com | | | | |
| ί | Physi this c | o | 1 Yes 2 No | 116 | 1 28a. Date | | ER/Outpatie | | DOA Othe | 4 L Nursin | g Home 5 R | | ~ - | | y) Son's 1 | -lome |
| n o | nding Physician: th. : After this certifice : funeral director, f | cate | | Pending Investigation | (Mon | th, Day, Year) | injury | M | work | | 28d. Describ | e now inj | ury occurre | a | | |
| Division | To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu | Medical Certificate: | | Could not be determined | | of Injury - At ng, etc. (Spec | home, farm, str cify) | | | | | on (Street and Number or Rural Route Number, Town, State) | | | | |
| | Hospita 24 hours E Funeral | ledical | (Check | edical Examine | er: On the bas | sis of examina | tion and/or inves | stigation, | in my opinic | on, death occurr | e, and due to the ed at the time, da | te and pla | ce, and due | to the ca | ause(s) and ma | |
| | To the within 2 To the comple | 2 | 29b. Signature and title of | | 4 | | | 2 | 9c. License | number | - | 29d. E | ate signed | (Month, | Day, Year) | |
| | | | 5 | 1ear | 1/ | - | | | 175 | 2027 | 242 | | 6/ | 27 | -/12 | _ |
| d | RW 5 | | 30. Name and address of | O B | onth | se of death (It | em 23a) (Type, | Print) | spit | al Re | 242 1 Para | ,ce | Fred | عدا | ck m | 87) |
| 67 | Sta Registr | | 31. Date filed (Month, Day, | JUN 27 | 7 2012 | egistr s Sig | nature A. | 10 | west | , | | | | | | |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 22297 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julieth 25, Geraldine Mae Sherman 2012 9:42 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dover Avenue Rose Haven Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 01/26/1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 1 🗆 M 2 💢 F 507-16-2939 90 Yrs Nebraska Usual Residence of Deceder 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 🗆 Yes 2 🗓 No MD Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7035 Dover Avenue 20714 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Black, White, etc. ö Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 'natural", 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) should be filed with and Mental Hygien is marked other th U.S. Government budget analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dewey 01son traumatic Mina Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frances G. Sherman, daughter 7035 Dover Avenue, Rose Haven, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ⊠ Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 06/30/2012 | Davidsonville, MD Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart (ailure. List only one cause on each line.) Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes To Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ours after death.

Ieral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a **To the Funeral D** Medical 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an 29d. Date signed (Month. Day, Year

1RW 8

State Registrar 31. Date filed (Month, Day,

d6 X

Ospital

leted cause of death (Item 23a) (Type, Print)

Registr

CHUH

31. Date filed (Month, Day, Year) 2012 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

istrar's Signature

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

OCME

June 23, 2012

Registrar

12-04582 William Schneck Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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|---|---|----|----|-----|---|---|
| | U | 12 | 22 | . 4 | J | |

| | | | 1- For State Registrar | Ce | ertificate of | Death | | R | eg. No. | UI | | |
|---|---|-----------------|--|--|--|---------------------------------------|---|--|-------------------------------------|-------------------------|-----------------------------------|--|
| | Physici Exam | | Decedent's Name (First, Middle,Last) William Schneck | | | | | 2. Date of Dea Month June 17, 2 | | ear | 3. Time of Death 1842 hrs | |
| 7 | | | 4a. Facility Name (if not institution, give s Chester River Hospital Center | | 1 | b. City, Town, Chesterto | or Location of De | eath | h 4c. County of Death Kent | | | |
| F | uneral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Ye | | Hrs. 8. Date of Bi | rth (MM/DD/YYY | Y) 9. Birti | hplace (State or | |
| Di | rector | | M10 00 7077 | 2_F 59 |) Yrs. | Months Da | ays Hours i | ^{Vlin.} 8/3/1 | | Enraine | n untry) MD | |
| | жпу | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Locati | on | | | | | 10d. Inside City Limits | |
| pur | . ■ | ō | MD Anne Arund | lel Sha | ady Side | | | | | | 1 Yes 2 X No | |
| Maryl | 28a-f | Director | 10e. Street and Number | • | | 10f. Zip Code | | 1 | 0g. Citizen of W | /hat Coun | try? | |
| ith the | 23a or notifie | | 1629 Columbia Beac | | | 2076 | | | USA | | <u> </u> | |
| r death w | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 1 Never Married 2 Married 1 | 2. Was Decedent Ever in U Armed Forces? Yes 2 K No | If Ye | es, specify Cuba | an, Mexican, Pue | Specify Yes or No erto Rican, etc.) | | e - Americ te, etc. | can Indian, Black, | |
| rs after | ıral", niner | ò | 3 Widowed 4 Divorced If or 15. Decedent's Education (Specify only it | Dates: | | Yes 2 X N | lo s <i>pecify:</i> ation (Give kind | | | Whit | | |
| 72 hour | "nati | eted | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | e. DO NOT use | | 16b. Kind of B | usiness/in | idustry | |
| MD 21215-0036 42 should be filed within 7 | ene. er thar Medica | Completed | | 1 | Projec | t Manag | er | | Honey | well | | |
| 15-C filed v | d Hygi | | 17. Father's Name (First, Mixele, Last) | | | | 18.Mother's Na Ruth Ki | me (First, Middle, I | M aiden Surname | 9) | | |
| 212 ald be | Menta mark ic even | ro Be | Anthony T. Schneck 19a. Informant's Name/Relationship (Type | | 19b. Mailing | Address (Stre | | or Rural Route Nun | nber, City or Tov | vn, State, | Zip Code) | |
| A 2 sh | lth and n 27 is | | Scott Schneck / Sc | | 1288 A | nglsey | Dr., Ri | va, MD 21 | | | , , | |
| Baltimore, ermit. Pages 1 an | of Hea If iter her tr | | 20a. Method of Disposition 1 Burial 2 X Cremation 3 | | Place of Disposi crematory or oth | | * | Date | 20c. Location | • | · — | |
| time t. Pag | rtant: | | 4 Denation 5 Other Specify: 21. Alguar re of the real Service Licen ee | | alas Cre | | | /23/2012 | | | | |
| Ba Permi | Depar injur | | 21. Ignature of Aneral Service Licen ee | <i>l</i> - | 22. Na | 72 Solo | ss of Facility G | eorge P. | Kalas F | unera | al Home MD 21037 | |
| | sician | | 23a. Part I. Enter the disease, or complica failure. List only one cause on each | tions that caused the death | n. Do not enter th | e mode of dying | g, such as cardia | c or respiratory arre | est, shock, or he | eart , | Approximate Interval | |
| | miner | | Immediate Cause (Final disease a. Hy | pertensive Atherosc | | vascular Di | isease | | | | Between Onset and Death | |
| | | | Sequentially list conditions, b | to (or as a consequence o | ot): | | | | | | | |
| | | iner | | | | | | | | | | |
| ited | d ansit | Medical Examine | (Disease or injury that initiated events resulting in death) Last Due | to (or as a consequence o | of): | | | | | | | |
| 760, icate be executed | physician and the burial - transit | dical | | MENDED | | · · · · · · · · · · · · · · · · · · · | | | · | | | |
| 7 60, ficate be | g physician the burial | - 3 | 23h Mas decedent pregnant in the | 3c. If yes, outcome of preg | | | | | 23d. Date of | | - | |
| Box 68 death certif | e attending for use as t | iciar | past 12 months? | Live birth Pregnant at time of de | ath | al death 3 er (Specify) | Ectopic preg | nancy | Month | Da | ay Year | |
| Bo, | 효후 | Physician | 1 Yes 2 No 9 Unknown | | | | | | | | | |
| Division of Vital Records, P.O. Box 68' Bospital or Attending Physician: The law requires that the death certif | signed by I be detach | <u>۾</u> | Part II. Other significant conditions con | ntributing to death but not r | esulting in the ur | derlying cause | given in Part I. | | _ | | ne cause of death? bly 4 Unknown | |
| of Vital Records, us Physician: The law require | s been s | Completed | | | | | | 24a. Was a | | | ppsy findings available | |
| Peco The law | 4 2 | e mo | | | | | | perfor | | death? | mpletion of cause of | |
| Ezi ii | certificate ector, page | BeC | 25. Was case referred to medical examiner? | | | 26.Plac | e of Death (Chec | | | | | |
| Physic Vision | er this | ٥ | examiner? 1 Yes 2 No 27. Manner of Death | I III III PAGEIR Z | ER/Outpatient 28b. Time of Ini | | | sing Home 5 1 | | | Scene | |
| on o | ath. he fune | ţi ii | 1 V Natural 5 Pending | 28a. Date of Injury (Month, Day,Year) | 200. Time of inj | · _ | ury at Work? Yes 2 No | 28d. Describe n | iow injury occurr | ed | | |
| Division | ufter de Directo in by t | Certification | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. Place of Injury - At ho | L ome, farm, street | factory, office | building, etc. | | | er or Rura | I Route Number, City | |
| spital 🖸 | hours a ineral I y filled | | 4 Homicide determined | (Specify) | | | | or Town, St | | | | |
| | within 24 h To the Fun completely | Medical | one) 2 ✓ Medicai Examiner:On | To the best of my knowleds the basis of examination and manner stated. | ge, death occurre nd/or investigation | ed at the time, d n, in my opinion | late and place, a n, death occurred | nd due to the cause I at the time, date a | e(s) and manner and place, and d | as stated lue to the | l. cause(s) | |
| | > F 0 | ž | 29b. Signature and title of certifier | 111 | | 29c. Licens | | | 29d. Date sign | | h, Day, Year) | |
| | | | 1 beather W | x /Cyg/ | JA, un | | M.E. OCM | Ē | June 22, 20 | J12 | | |
| HE | | | 30. Name and address of person who comp Theodore M. King, Jr., MD. | pleted cause of death Mem Assistant Medical E | xaminer 9 | 00 W. Baltir | nore Street, | Baltimore, MD | 21223 | | | |
| 111- | S+ | ate | 31. Date filed (Month, Day, Year) JUN 2 5 201 | 32. Redistrar's Signatu | ire 🔏 🔏 | ww | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Physician/ 2012 Carolyn Beth Cunningham Smith June 2:35 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1343 Ivy Hill Rd. Cockeysville Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 092-20-0627 88 **Director** 1 M 2X F Feb. 24, 1924 Indiana Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d, Inside City Limits at Director injury or other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 X No Cockeysville MD Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 0 Funeral 23a U.S.A. 21030 1343 Ivy Hill Road items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ö þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Business Woman Media and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Frederick Cunningham Ester Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timberpark Court, Timonium, MD 21093 Dr. Frederick G. Smith/son 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Important: If ite any injury or of 1 Burial 2 ☐ Cremation 3 Removal from State Queens Port Cemetery 6-22-2012 Keyser, WV 4 Donation 5 Other (Specify) 21. Signature of Fu eral Sovice Dcense 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Pregnant at time of death the Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part use contribute to the cause of death? signed by page 2 should be 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No certificate Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 🖸 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum_{\text{Nursing Home}} \) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death. To the Funeral Director: After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accider
Suicide Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu

CALS

Registrar

DHMH 17 Rev 06-2011

gistrar's Signatur

Vacacity MD

1075 3 Falls No. Svite 255. Lutherville MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19^{Day}2012^{Year} JUNE 5:10 AM LILLIAN J. SHIELDS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY 9111 CHARRED OAK DRIVE BETHESDA Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min Aug (Month 5 Day, 1 Year) 21 1 M 2 F 436 80 2464 90 LOUISIANA Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director X ☐ Yes 2 ☐ No BETHESDA MD MONTGOMERY 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 20817 9111 CHARRED OAK DRIVE USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", Completed 3X Widowed 4 □ Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be file Department of Health and Mental Important: If item Z7 is marked c any injury or other traumatic eve ones. 2 EDWARD JOHNSON ISADORA WILLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 CHARRED OAK DR. BETHESDA MD 20817 CLARA VALENZUELA/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ROCKVILLE MD 4 ☐ Donation 5 ☐ Other (Specify) 6/23/12 PARKLAWN CEM. 20010 22. Name and Address of Facility WATSON FH 3435 14th ST NW WASH. DC to Word 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. AORTIC VALVULAR DISEASE Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence on if any, leading to miniedate cause. Enter Underlying Cause (Disease or linjury that initiated events as the burial transit To the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 X No Pregnant at time of death Month Day Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MITRAL REGURGITATION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a Was an autopsy performed? Yes 2 K No 1 Yes 2 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 $\bf X$ Residence 6 \square Other (Specify) 2 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work?
1 Yes 2 No Investigation (prompleted filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an 6/22/12 MD 025647 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ANDREW J LEE

26

31. Date filed (Month)

JR MD

alla

110 IRVING ST., N.W. WASH. DC 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 18. Thaddeus Matthews June 6:30 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8406 Shadeland Road Laurel Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-44-7953 Director 1 X M 2 □ F 68 Feb. 11, 1944 MD Usual Residence of De item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 X No Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8406 Shadeland Road 20724 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. and Mental Hygiene. 1 Never Married 2 X Married ģ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give ar or Dates. 1962-87 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Henry Savage Margaret Virginia Bailey permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacinta A. Savage/Wife 8406 Shadeland Road, Laurel, MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State Arlington National Injury or 1 ABurial 2 Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Embolism disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Prostate Cancer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending physi for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pulmonary Hypertension, Sarcoidosis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical of Vital director, Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\begin{array}{c} \beq \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{array 1 Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 💹 Natural 5 Pending Division ours after death.

Ieral Director: Aft
filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jun 21, 2012 MD17214 HI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Darrell J. Baranko,

26 2012

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

8901 Wisconsin Avenue, Bethesda, MD 20899

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Smith Delano Cloyd Physician/ June 29 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Examiner Allegany Health Nursing & Rehab Ctr Cumberland 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours 220-32-4220 75 1274877936 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Cumberland Allegany 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21502 502 Baltimore Avenue Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1

Yes 2 □ No
If Yes, Give 1 Black, White, etc. Š 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Tire and Rubber Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine မ Smith Mildred Wagner Raymond Cloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14010 Spruce Springs Road, Cresaptown, 19a. Informant's Name/Relationship (Type, Print) Ellen R. Hill / Niece Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cumberland Crematory 07/02/2012 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cumberland, MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, F.A. ture of Funeral Fun Sign 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition ARCINON Priysician/ BRONCHOA MO Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Dav 5 Other (specify) Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🗹 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: Aft pleted filled in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

mel State

16

31. Date filed (Month, Day, Year) 0 2 2012

29b. Signature And title of certifier

only one)

32. Registrar's Signature Darks

30. Name and address of person who completed gause of death (Item 3 a) (Type, Print)

Robustiano J. Barrera, Jr., M.D.,

Registrar

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

200 Glenn Street, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NORWOOD GARY TULL 10:08PM 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** McCready Memorial Hosiptal Crisfield Somerset 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1^{Year} 1951 June 14 1**X** M 2 □ F Director 215-58-6114 Usual Residence of Decedent or 28a-f show e notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 □ No <u>Crisf</u>ield Maryland Somerset * 23a o. 10e, Street and Number 10g. Citizen of What Country? Funeral 10 Anchor Drive 21817 USA "natural", or items 23 dical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2XXMarried 1 ☐ Yes 2 💢 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced ed wh. al Hygiene. her than "naı.. ه Medical Ey Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Seafood Waterman marked other of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norwood Harvey Tull Eileen Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Anchor Drive - Crisfield, MD 21817 Cheryl Tull (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Sunnyridger Mem. Park 6/26/2012 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatura Funeral Service/Lipenser

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOM B06 W. Main St. - Crisfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition a odices Pnysician/ Médical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The law has certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Le ath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print John Whiteler, ws 305 1085)

State Registrar

JUN 27

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A^{M} 2012 10:05 4c. County of Death Somerset 9. Birthplace (State or Foreign Mary Land 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry

> Approximate Interval Between Onset and Death

Month

1 Yes 2 No

DHMH 17 Rev 06-2011

State Registrar STREET

S. DIVISION

1415 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DONALD THOMPSON PM JUN 2012 5:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WALTER REED NATIONAL MEDICAL CENTER BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** Months Days Hours Min 1 1 1 2 1 7 1 9 5 4 217 68 6350 57 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director Charles MD Nanjemoy 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral 7995 Gilroy Road 20662 USA items be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner rmed Forces?

XYes 2 No Black, White, etc. American ò þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed Indian 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Communications Operator U.S. Marines alth and Mental Hygie

27 is marked other

traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Roy Thompson Theresa Savov Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 7995 Gilroy Rd.Nanjemoy, Beverly Thompson/Wife MD 20662 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 6/22/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterns Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ISCHEMIC CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** COR PULMONALE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or se a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last CARDIOGENIC SHOCK Due to (or as a consequence of) Physician/Medical ASYSTOLE The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Id be detached for 9 Unknown Part II. **Ot**he<mark>r significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 2 this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 XNatural work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

U 4

> State Registrar

only one) 29b. Signat

30. Name and

ROLF

and title of certifier

dress of person who

GRANING

JUN 26 2012

Registrar's Signatur

ompleted cause of death (Item 23a) (Type, Print)

BETHESDA, MD 20889 Back

29c. License number

VA 0101244007

WALTER REED NATIONAL MEDICAL CENTER

29d. Date signed (Month. Day, Year,

JUN 25 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 23, 2012 JEANNETTE EUDORA CLARK THURMOND JUNE 12:50P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF WALDORF CENTER GENESIS HEALTHCARE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Dav. Year) Months Days Hours 365-34-0858 91 1 □ M 2**X** F Director MAY 1, 1921 MARYLAND Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Director be notified 1 🏋 Yes 2 □ No WALDORF MARYLAND CHARLES 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or 23a Funeral 20602 UNTTED STATES 4140 OLD WASHINGTON ROAD Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status 5 þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 'natural", 3 K Widowed 4 □ Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. 4 YEARS Elementary/Secondary (0-12) SCHOOL TEACHER EDUCATION other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I JAMES WILLIAM CLARK, SR. EVA ELNORA KEY CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 10659 WATER HICKORY COURT, WALDORF, MARYLAND 20601 WILLA MAE CLARK PARKER/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ö Department of Important; If any injury or METROPOLITIAN CHURCH CEM. JUNE 29, 2012 INDIAN HEAD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licenses THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LIDIA C. THORNTON JOHNSON MOO583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OTIC CARDINASCULAR Immediate Cause (Final Ph_ician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Ď Day Pregnant at time of death 1 Yes 2 No þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆

PHILÍP WISOTSKY, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and til

30. Name a

nd address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 18545

12070 OLD LINE CENTRE, SUITE 207, WALDORF, MARYLAND 20602

29d. Date signed (Month, Day, Year)

JUNE 25, 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}012 June 16, Physician/ Willing Twilley Beula 03;55 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 617 Pacific Ave. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Year) Director 214-10-9935 1 □ M 2 🛣 F 99 Yrs. 03/14/1913 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important if item 27 is marked other than "nature!" any injury or other traumatic events any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Worcester Ocean City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21842 USA 617 Pacific Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Property Management Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Ann Morris Clayton C. Willing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5356 Royal Mile Blvd, Salisbury, MD 21801 Robert Dashiell/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place
Wicomico Memorial
Park 1 Durial 2 Cremation 3 Removal from State 6/19/2012 Salisbury, MD 4 Donation 5 K Other (Specify) tombment 21. Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ 95 CVD disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the buriel-transi tha Hospital or Attanding Physician: The law requires that the death certificate be executed Lause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day g 🗌 Unknown g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.
Funaral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hound to the form the form the form completely file. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2,804 5 west 1415 5. DIVISION NATERA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

19 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Florence Elizabeth Tice 2012 ปั๊นไร 2:30 A.M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Nursing Home Williamsport If Under 1 Year I If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 0ct.28,1940 Pennsyl vania 192-32-9112 Director 1 🗆 M 2 🗶 F 71 or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Pa. Greencastle Franklin 10e. Street and Numbe 10g. Citizen of What Country? Funeral 17225 U.S.A 30 E. Madison St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No 1 Never Married 2 Married þ 72 hours after 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. ed other than "natural", event, the Medical Exar Specify: White 3 Widowed 4 XDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nettie Florence Custer Frederick Joseph Hepher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Fort Loudon Rd. Mercersburg, Pa. 17236 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Randy E. Monn (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory Smithsburg.Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg.Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ONE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Duerto (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy perform 2 🗌 No Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ျဉ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 06 leted cause of death (Item 23a) (Type, Print) Registrar

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| | | - State Registrar | | | Cei | rtificate of | Death | | | Reg. No | 20 | 12 2 | 231 |
| Physicia | m | 1. Decedent's Name (First, Middle | e, Last) | | | _ | | | 2. Date of De | eath Da | ay Y | ear | e of Death |
| /Medic | | KENNETH VAN LOC | | | | | | | June | 20 | , 20 | | TOAM |
| Examin | er | 4a. Facility Name (If not institution | _ | | | 4b. City, Town, o | or Location | of Death | | | . County of | | |
| | | FUTURE CARE OF 5. Social Security Number | | EAKE Age (In yrs. | lact hirthday | ARNOLD If Under 1 Year | If Under | 24 Hrs | 8. Date of Bi | _ | | RUNDEL Birthplace (Sta | to or Coreiro |
| Funeral Director | | 199-22-0494 Usual Residence of Decedent | 1 X M 2 □ F | 81 | Yrs. | Months Days | Hours | Min. | 8. Date of Bi (Month, Di 09/29/] | 1930 | ì | Country) NEW JERS | |
| /land | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Insid | e City Limits |
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| er death with the Marylar items 23a or 28a-f show | Funeral Director | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Ci | itizen of Wh | at Country? | |
| 23a ust b | la l | 207 TYLER AVE | • | | | 21663 | | | | USA | | | |
| items | nue | 11. Marital Status | 12. Was Decede Armed Force | es? | S. 13. | Was Decedent of I | Hispanic Or an, Mexica | rigin? (Spen | ecify Yes or No Rican, etc.) | 0- | | American India: White, etc. | a, |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Marked other pain in a nation once. | þ | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced | If Yes Give | | | 1⊡Yes 2∏XNo | Specify | | | | Specify: | WHITE | |
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| ld be lenta ked c | To Be | CHRISTOPHER STE | EPHEN VAN L | OON | | | HET. | EN BO | OUMA | | | | |
| shou and N mar umat | - | 19a. Informant's Name/Relations | | | 19b. Mailir | ng Address (Stree | | | | ber, City | or Town, St | ate, Zip Code) | |
| alth alth a | | CURT VAN LOON / | / SON | | P.O. | BOX 1166 | ST. | MICH | AELS, M | 1D 21 | 1663 | | |
| ages 1 sent of He ort: If Item | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | 3 ☐ Removal from St | ate OXF | Place of Disponentery, cree ORD CE | esition (Name of matory or other pla EMETERY | ice) | | 7/2012 | | ocation - Ci | ty or Town, State | э |
| mit. F portar ortar Inju | | 21. Signature of Funeral Service | | | 7 | ELLOWS Addr | essof Facili | ₩ост | N C NIET. | TNT A IM | PHART | AT HOME | . D A |
| B B E B | | Ways ! | R. MERC | E (2 5 | | O S. HAR | RISON | ST. | EASTON | VIVALII V, MI | 2160 | (AL HOME)1 | , F.A. |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | only one cause on each | h line. | brova | er the mode of dy | | | | arrest, | | Approxi Interval Onset a | imate Between and Death |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | С | as a conseq | | | | | | | | | |
| e law requires that the death certificate bhas been signed by the attending physici e 2 should be detached for use as the bu | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | th 2☐ Feta nt at time of o | Ideath 3 | ☐ Ectopic pregnan ☐ Other (specify) | | | | | 23d. Date Month | | Year |
| s that gned b | by P | Part II. Other significant condition | | | ulting in the u | nderlying cause gl | ven in Part | l. | 23e. Did | tobacco | use contrib | ute to the cause | of death? |
| quire en sig uld bi | od be | Cardion | mapathy | | | | | | 1 🗆 | Yes 2 | No 3 | ☐ Probably 4 | Unknown |
| he law re e has bee tge 2 sho | Completed | Debetes | meltit | us | | | | | 24a. Was auto perf | | pri- de: | ere autopsy findi or to completion ath? | of cause of |
| an: T tificat or, pa | | 25. Was case referred to medica | 1 | | | | OF Plan | a of Dooth | 1 ☐ Yes | 3 | 0 1 |]Yes 2 □No | |
| yslcia is cer direct | o Be | examiner? 1 ☐ Yes 2 ☑ No | Hospital: | patient 2 🗆 | ER/Outpatie | nt 3 DOA Ot | h | | me 5 ☐ Res | | 6 □Other | (Specify) | |
| g Ph ter thi | Li l | 27. Manner of Death | 28a. Date of | | 28b. Time o | f 28c. Inju | ry at | | 28d. Describe | | | | |
| ath. nr: Afr | atio | 1 Accident 5 ☐ Pendin investi | gation | Day, rear) | linjury | M 1 E | Yes 2 | No No | | | | | |
| al or Atte s after de il Directo ed in by th | Certification: To | 3 Suicide 6 Could 4 Homicide determ | pined 28e. Place of | f Injury - At ho , etc. <i>(Specil</i> | ome, farm, str | eet, factory, office | | | 28f. Location City or To | (Street a | nd Number le) | or Rural Route i | Number, |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical (| 29a. Certifier 1 Certifyle (Check only one) 2 Medical | ng Physician: To the b Examiner: On the bas and manne | is of examina | owiedge, deat ation and/or in | h occurred at the to extigation, in my | ime, date a opinion, de | and place, ath occurr | and due to the | e cause(, date ar | s) and man nd place, an | ner as stated. d due to the cau | se(s) |
| To th withii To th | Me | 29b. Signature and title of certifie | | | | 29c. Licen | se number | | | 29d. Da | ate signed (| Month, Day, Yea | ir) |
| CAT | | Misne | gi, m. | 6 | | D5 | 7531 | | | Ju | LME | 20, 2 | -012 |
| AU+L | | 30. Name and address of person | who completed cause | of death (Item | n 23a) (Type, | | Sin | t Z | 'N YO | . 14. | civil | In only | |

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ June 24, BERTHA ANN WALTER 4:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) **Director** 177-16-1057
Usual Residence of Deceden 1 M 2 K F Dec. 25,1915 New Jersey 96 if Heelth and Mentel Hygiene. Item 27 is marked other then "neture!", or items 23e or 28e-f show other treumetic event, the Madical Experiment must be notified at 10b. County 10a, State within 72 hours efter death with the Merylend 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Garrett Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10800 Montrose Ave., Box 160 20896 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Charles Ernest Happersett Elva Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Heelth a John E. Walter/Son 4515 Gregg Rd., Brookeville, MD20833 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pege 1 permit. Pege 1 a
Depertment of P
Importent: If Ite
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Cemetery 6/28/2012 Rockville, MD Signature of Furnial Service Liberary eny In 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Laytonsville, MD 20882 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Tiljury that initiated events Due to (or as a consequence of): Exam e Hospital or Attending Physician: The law requires that the death certificete be executed 24 hours efter deeth.

Puneral Director: After this certificate has been signed by the ettending physicien end letely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 SANDERP SITARMA VEIRS

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ ENE Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City. Town, or Location of Deat Examiner Ridge JOTC . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Country) Ø Director or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State by Funeral Director 1 🗆 Yes 2 XNo OCK UT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 📉No Specify: Specify: and Mental Hygiene, is marked other than "natural", 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired Heating High ton HAL Speials (Specify only highest grade completed) - Ventilation Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 2 19a Informant's Name/Relationship (Tv. 19b. Mailing Address (Street and Number or Rural Route Number, City or brother 6515C permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place.
Out Lady of Fatimalism Burial 2 Cremation 3 Removal from State Shenandoah. Other (Specify) 4 Donation . Signature of Fundral Service Licenses disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate 23a. Part 1. Enter the Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Esquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (dr as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an his certificate has b Il director, page 2 sl yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 2 1 \square Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After thi Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending within 24 hours af er dea.h.

To the Funeral Director Af
completed filled ir by thε fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on 29b. Signatu

TLS 5

State Registrar

DHMH 17 Rev 7/2009

OLLINS AVE

WO

who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 Physician/ June 25, 9:19 ам L. Winters Pauline Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Charles Waldorf 1117 Clark Ave. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex Social Security Number **Funeral** (Month, Day, Year) Months Hours Min. 220-28-0854 Director 1 🗆 M 2 🗓 F 79 05-22-1933 Delaware Usual Residence of Decedent 28a-f show 10d. Inside City Limits 0a. State 10b. County 10c. City. Town or Location at Director th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified . 1 Yes 2 X No Waldorf Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20602 United States 1117 Clark Ave. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give þ altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lily Layfield William Layfield Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a item 27 i 10637 Princess Diana La Plata, Maryland 20646 William Winters/Son injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or other 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-03-2012 Cheltenham, Maryland Veterans Cem. Signature of Funeral Service License 22. Name and Address of Facility Arehart-Echols Funeral Home, PA 567 LaPlata, Md. 20646 P.O. Box MO0945 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arrespiratory arrespondent on the cause of the caus Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ BW CK Medical resulting in death) Dut (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) transit. burial-1 attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: use s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Year Hospital or Attending Physician: The law requires that the death Pregnant at time of death detached the 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Rrobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nas perform death? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \quad Yes 27. Manner of Death 28d. Describe how injury occurred After t Certificate: 1 Natural 5 Pending 2 No s after death. Accident
Suicide Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 🗌 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier within 24 hou To the Funel completely fi in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated curred the time date and place, and due to the cause si and manner as stated. (Check Cartifying Nurse Practitioner: To the bee death 29d. Date signed (Month, Day, Year) 29b. Signature o 30. Navi ho completed cause of death (Item 23a) (Type, Print) 20103 31. Date Med State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0615 ARENCE Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c, County of Death Examiner Tate Hospice House Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min Hours Director 219-84-7940 1 🏋 M 2 🗆 F Yrs 48 Ju1y 2 1963 Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Anne Arundel Annapolis 1 🗌 Yes 2 💢 No 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be by Funeral 21403 950 President St. Apt A3 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. 1X Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Restaurant uth and Mental Hygier 27 is marked other t r traumatic event, th Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mary A. Butler James Wright Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 813 C Betsy Ct. Annapolis, Md. 21401 Nikisha Wright(Daughter) other! altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) Department of Important: If any injury or 0 6-21-12 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Mindame a Roman Section Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause ach line. Approximate nowl Immediate Cause (Final Physician Quomous disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lot as a consequence on. Exami or Attending Physician: The law requires that the death certificate be executed and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: after death. Director: After 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the be of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

900 W. Baltimore Street, Baltimore, MD 21223

istrar's Signature

ne and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Laron Locke MD

31. Date filed (Month, Day, Year) 6 201

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Watson 6:44 AM Mary 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis cial Security Number 7. Age (In yrs. last birthday) 75 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 217-56-3165 Months Hours Min (Month, Day, Year) Director 1 🗆 M 2 🙀 F Yrs 2/7/1937 Scotland Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Queen Anne's Chester 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2633 Cox Neck Road 21619 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Health Assistant Public Schools permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Conroy Annie Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Archibald Watson - Husband 2633 Cox Neck Road, Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 6/25/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Prevenicion/ Nemorrhage barachno disease or condition resulting in death) Medical **Examiner** 1200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to to, as a consequence on Exami The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 12 months? 2 No in the past 12 Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 2 No 1 Tes Yes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 🔼 No Other: : After this c e funeral dir မ 🔼 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 1/M Natural 5 Pending neral Director: A filled in by the fi 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

Registrar DHMH 17 Rev 06-2011

State

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WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26201

29b. Signature and 📶 le 🎢 certifier

6934

gistrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D54488

Aviation Blud, Ste B,

29d. Date signed (Month, Day, Year)

2012

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Month Robert Eli White Jr 21. 2012 11: 30a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Sprina Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign ¹**X** M 2 □ F April 27 **Director** 327-24-0713 82 Illinois or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Kensington <u>Montgomery</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 11208 Dewey Road USA 20895 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 1951 – If Yes, Give Year or Dates. 1953 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) e 1 and 2 should be filed within 72 lof Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med Department of Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Interior Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Eli White Sr Leona Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sadie Poinsett - Spouse 11208 Dewey Road, Kensington, MD 20895 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 6/27/2012 Brentwood. Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, i i n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burlal fame that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0064624 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, MD 9701 State Registrar

DHMH 17 Rev 7/2009

Registrar

Judy

egistrar's Signature

H. Jospeh Herbert, M.D.

JUN 26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. i. Decedent's Name (First, Middle, Last) 2. Date of Death

JM971Pe 24Pay2012*ear 3. Time of Death Physician/ Zeffiro 12:44a _м Gloria Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Kensington Park Retirement Kensington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 84 Months Days Min. 8 427 7927 1 M 2 XF Hours 173-20-0260 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland all Hyghen.
Id Hyghen.
d other than "natural", or items 23a or 28a-f show yent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3616 Littledale Road 20895 USÁ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc.
White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Case Worker State of Pennsylvania Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last)
Cesido Tucceri 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Rossi ೨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Memory Court Silver Spring, Md. 20904 Jo A. Talley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mon Valley Mem Pk 7/03/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Donora, PA. 4 ☐ Donatjon 5 ☐ Other (Specify) PHIME ADERINALDI FUNERAL SERVICE, P.A. 21. Signatur, f Funeral Service 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Congestive heart failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Dysphasia Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo ło Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autops, performed? 2 🗌 No 1 Tes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) assisted living examiner? Hospital: 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 🗀 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, npleted filled in by determined City or Town, State) 24 hours a Funeral L Medical 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge; death at the time, date and place, and due to the 29b. Signatura 29c. License number D53691 29d. Date signed (Month, Day, Year) June 26, 2012

Registrar
DHMH 17 Rev 7/2009

State

3200 Tower Oaks Blvd. Rockville, Md 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy M.D.

26

31. Date filed (Month, Day, Year

JUN

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUN 233 2012 7:32 P M CHRISTINE ZIRPS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death WALTER REED NATIONAL MEDICAL CENTER MONTGOMERY BETHESDA 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year, June 11, 19 Country) New York **Director** 099 - 26 - 2061 1930 Usual Residence of Decedent show 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Virginia Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1902 Toll Bridge Court United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Executive Assistant Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other မှ George Commine1 Marianthe Catacosinos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Toll Bridge Court, Alexandria, VA 22308 Christos Zirps, Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Donation 5 Other (Specify) Oak Hill Cemetery 7/2/2012 Nyack, NY 21. Signative of Fundal enuce Linensee 22. Name and Address of Facility Everly Community Funeral Care M00709 6161 Leesburg Pike, Falls Church, Virginia 22044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition HIGH GRADE INTRACRANIAL GLIOMA resulting in death) Medical Examiner DEMENTIA Sequentially list conditions, if tany, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ending physician and r use as the burial-tresit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 X No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 XNo 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 X No 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending Investigation Could not be 1 🗌 Yes 2 🖵 No after death Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

20

ANDREW G.

31. Date filed (Month, Day, Year)

LETIZIA.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER

DE

C1-0007581

BETHESDA, MD 20889

JUN 26 2012

| 12-05231 | |
|-----------------|--|
| Leroy Arrington | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| eroy Arrington | | State of Maryland / Do | epartment of Ce <i>rtificate of</i> | | Mental Hy | | eg. No. 20 | 12 2232 | | |
|---|---|---|--|---|-------------------------|------------------------|----------------------------|---|--|--|
| Physici | | 1. Decedent's Name (First, Middle,Last) | | | | Date of Deat Month | th Day Year | 3. Time of Death | | |
| Medical Exami | ner | Levoy Arrington 4a. Facility Name (if not institution, give affect and number) | | 4b. City, Town, or Loc | etics of Dooth | July 11, 20 | | 1425 hrs | | |
| A. | | Union Memorial Hospital | | Baltimore | allori of Deali | | 4c. County of D | real() | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In | yrs. last birthday) | If Under 1 Year | f Under 24Hrs. | 8. Date of Bir | | . Birthplace (State or | | |
| Director | | 214-78-2971 12M 20F | 52 Yrs. | | Hours Min. | 01/09 | 1/1960 1 | oreign Country) MD | | |
| | | Usual Residence of Decedent | 90 | | | 101/01 | 111001 | 710 | | |
| r any | | | City, Town or Locati | | | | | 10d. Inside City Limits | | |
| Maryland 28a-f sbow d at once. | ь | | Baltim | ore | | | | 1 ∑ Yes 2 No | | |
| Mary r 28a- | Director | 10e. Street and Number | | 10f. Zip Code | _ | 10 | og. Citizen of What | Country? | | |
| with the Maryland ms 23a or 28a-f sho be notified at once. | <u></u> | 4405 ST. Georges Avenu | | 2121 | | | USA | | | |
| ath wi | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Forces? | If Ye | s Decedent of Hispan es, specify Cuban, Me | | | - 14. Race - A White, e | merican Indian, Black, tc. | | |
| ter de | | 1 Yes 2 X | | Yes 2 No sp | pecify: | | Specify: L | Black | | |
| urs af utura l | d by | 15. Decedent's Education (Specify only highest grade complete | ed) 16a, Decedent | t's Usual Occupation (| (Give kind of w | | 16b. Kind of Busin | | | |
| 5 72 ho un "nu | lete | Elementary/Secondary (0-12) College (1-4 or 5+) | | ost of working life. DO | NOT use retire | ed) | 0. | , | | |
| 5-0036 led within 72 hours at tygiene, other than "natural the Medical Examin | Completed | /0 | Car | egiver | | | PRIVO | ite | | |
| 15-C | ပိ | 17. Father's Name (First, Middle, Last) | | | 1 | | flaiden Surname) | | | |
| 21215-0036 Uld be filed within 7 Mental Hygiene, marked other than | To Be | Charles Linberg Arringto 19a. Informant's Name/Relations (Type, Print) | 19h Mailine | Address (Street and | YA E | Blanto | her City or Town S | State Zin Code) | | |
| O 등 등 등 급 | - | Dra Lewis (MOTHER) | 1112 | | | | | | | |
| FF 정문설득 | - 1 | 20a. Method of Disposition | 20b. Place of Disposi | ition (Name of cemete | ery, | Date | 20c. Location - Cit | y or Town, State | | |
| nor of other | | 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: | On- Cite / | Class to a | , 7/ | 18/2012 | Baltin | rore, Md | | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite | | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee | 22. N | ame and Address of | acility Var | ARHN GI | CEENE FUN | nore, Md emiservices | | |
| E F C F CO | | 23a. Part I. Enter the disease, or complications that caused the disease. | 504 49 | OS York A | Road. L | Balto, | Md. 21 | 212 | | |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the d failure. List only one cause on each line. | eath. Do not enter th | ne mode of dying, such | h as cardiac or | respiratory arre | est, shock, or heart | Approximate Interval Between Onset and | | |
| /Medical Examiner | ĺ | Immediate Cause (Final disease a Morphine Int | | | | | | Death | | |
| * | | or condition resulting in death) Due to (or as a consequent | ice of): | | | | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate Due to (or as a consequential property) | ice of): | | | | | | | |
| | miner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in (bath). Last events resulting in (bath). Last | oco of): | | | -11-1 | | _ | | |
| uted id ansit | Еха | events resulting in death) Last Due to (or as a consequer d. | 08 017. | | | | | İ | | |
| iO, e be executed ysician and burial - transit | edica | x UNPENDED AMENDED 23a,pt | t.II,27,28 | Ba-f,per m | e,g935 | 1-9-13 | sm | | | |
| 760, cate be physic he bur | | IF FEMALE: 23c. If yes, outcome of | pregnancy | | | | 23d. Date of del | ivery | | |
| 687 ertific | jan/ | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time | -6 -111- | _ | Ectopic pregnar | псу | Month | Day Year | | |
| Box 6876 e death certificate the attending phy ed for use as the l | Physician/M | 1 Yes 2 No 9 Unknown 9 Unknown | ordeatti 5 Oth | ner (Specify) | | | 1 | | | |
| that the de detached f | | Part II. Other significant conditions contributing to death but | not resulting in the u | nderlying cause given | n in Part I. | 23e, Did to | bacco use contribut | e to the cause of death? | | |
| res that the signed by | d b | Cardiomegaly, Diabetes Mell | itus | | | 1 Yes | 2 No 3 | Probably 4 🗸 Unknown | | |
| ords v requi | lete | | | | | 24a. Was a | | e autopsy findings available to completion of cause of | | |
| eco he law te has | Completed | | | | | perfor | med? deat | | | |
| Vital Rec ysician: The his certificate director, page | Be | 25. Was case referred to medical | | 26.Place of D | Death (Check o | | | | | |
| Vit. | 0 0 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 | ER/Outpatient | 3 DOA Othe | er ₄ Nursing | Home 5 | Residence 6 C | Other. | | |
| 27 Manager of Dooth 29a Date of Jajuny 29b Time of Jajuny 29a Jajuny at Work? 129d Date of Jajuny accounted | | | | | | | | | | |
| sion ttend death. ctor: | atic | Natural 5 Pending Pending Investigation fd 7-6-12 | fd 2:09 | | | unknown | | | | |
| ivision of At | Certification: | Suicide Could not be | At home, farm, stree d at home | t, factory, office buildii | | or Town, St | tate) 4405 St | Rural Route Number, City Georges Ave | | |
| ospita hours hours | | 4 Homicide | 1.1. 4.4. | and at the Alexander | | Baltimo | | - 1 | | |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: | Suicide 6 Could not be determined (Specify) found at home or Town, State) 4405 St. Georges Ave Baltimore, MD. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation. in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| To wit | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of the cause | | | | | | | | | |
| | | W-7 /c | | O.C.M.E | | | July 13, 2012 | | | |
| 10 | | 30. Name and address of person who completed cause of death | (Item 23a) | | - | | _ | | | |
| 1 | | Donna M. Vincenti, MD Assistant Medical E | xaminer 900 | W. Baltimore Str | reet, Baltim | ore, MD 21 | 223 | | | |
| St Regist | ate | | nature | / | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY JULIA AXELROD 2:40 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE, MARYLAND HEBREN HOME OF GREXTER WASHINGTON MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 289-28-1309 9/15/1928 Poland Director 1 🗆 M 2 🍱 F Usual Residence of Decedent shov filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Montgomery Potomac 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20854 4 Cloverbrooke Court 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Lieb Feldman Rose Bendler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Cloverbrooke Court Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lorraine A. Lippman-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Anshe Sfard Cemetery 1 Burial 2 Cremation 3 X Removal from State 07/14/2012 4 Donation 5 Other (Specify) Akron, Ohio Theme and rooms or other trary sage! Funeral Direction, 21. Signature of Euneral Service Licen Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph, sician/ OLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury r the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li recur Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🔀 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 M Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 1/3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0071782 JULY 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE ROND, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

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| 12-05221 | |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| nice Madelyn | е Ве | State | e of Maryland / Dep | artment of | | Mental Hy | | 20 | 112 2232 |
|---|----------------|---|---|------------------------------------|---|--------------------|-----------------------------------|-------------------------------|--|
| Physici | an/ | Registrar 1. Decedent's Name (First, Middle, La | | Timodio or I | | | Reg 2. Date of Death | g. No. | 3. Time of Death |
| ledical Exami | | JANICE Madely | ine Bell | | | | Month July 11, 20 | Day Year 12 | 0035 hrs |
| | | 4a. Facility Name (if not institution, a 3904 Kimble Road | ive street and number) | 4t | . City, Town, or Loc Baltimore | cation of Death | | 4c. County of [| Death |
| Funeral | | | Sex 7. Age (In yrs. | last birthday) | | If Under 24Hrs. | 8. Date of Birth | (MM/DD/YYYY) S | Birthplace (State or |
| Director | | | _M 2 ⊠ F | 68 Yrs. | Months Days | Hours Min. | 02/05 | / IF | oreign Country) VA |
| | | Usual Residence of Decedent | | | | | | , , , , | 771 |
| w any | | 10a. State 10b. County | 10c. City | , Town or Locatio | | | | | 10d. Inside City Limits 1 Yes 2 No |
| Aaryland 28a-f shnw 1 at once. | rector | MD 10e. Street and Number | | | More 10f. Zip Code | | 140 | g. Citizen of What | |
| with the Maryland ns 23a nr 28a-f shr pe notified at once | Jirec | | 0.1 | | 21218 | 2 | 10 | USA | Country? |
| with the 18 23a ne 23a | Funeral Di | 3904 Kimble A | Was Decedent Ever in L | | Decedent of Hispar | nic Origin? (Spe | cify Yes or No- | 14. Race - A | merican Indian, Black, |
| death or item | une | 1 Never Married 2 Marrie | Armed Forces? 1 Yes 2 No | If Yes | , specify Cuban, M | fexican, Puerto R | tican, etc.) | White, e | tc. IFrican |
| hours after death natural", or iten Examiner must b | by F | | ed If Yes, Give Year or Dates: | | es 2 No s | | | Specify: A | Merican |
| | | 15. Decedent's Education (Specify Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. Decedent's during mos | Usual Occupation t of working life. DO | O NOT use retire | | 16b. Kind of Busin Balto C | ess/Industry CITY DEPT OF |
| 0036 within 72 iene. er than " | Completed | 12 | 4 | Soci | al Work | Ker | | Social | SERVICES |
| 5-0036 Led within 7 Hygiene. Inther that | | 17. Father's Name (First, Middle, Las | it) | , , | | Mother's Name (| | aiden Surname) | <u> </u> |
| 21215-0036 uld be filed within 7 Mental Hygiene, marked nither than | Be | Vergil Bell 19a. Informant's Name/Relationship (| (Turn Dista) | AOF Marilian | Address (Street an | ntonel | 1e Mo | ore | |
| MD 2 d 2 shoul lth and M n 27 is m | ပ | Brenda Cann | | | | | | | |
| | | 20a. Method of Disposition | | | | | | | 4 · VA · 23464 ty or Town, State |
| Baltimore, vermit. Pages 1 an Department of He important: If ite | | 1 X Burial 2 Cremation 3 4 Donation 5 Other Specif | Removal from State | crematory or othe | emprial | 7/2 | 1/12 | Baltin | nore, MD |
| altii mit. J partm porta | | 21. Signature of Funeral Service Lice | ensee | 22. Na | ne and Address of | Facility Va u | 19hn G | REENE FU | ineral services |
| | | Mobia Mai | 40 1101540 |) 49 | os York | Road. | Balto | , MO.2 | 1212 |
| Physician //Medical | | 23a. Part I. Enter the disease, or comfailure. List only one cause on e | each line. | i. Do not enter the | mode of dying, suc | ciras cardiac or i | espiratory arres | st, snock, or neart | Approximate Interval Between Onset and Death |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consequence of | | vascular Disea | ase | | | |
| | Ŀ | Sequentially list conditions, |). | | | | | | |
| | nine | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a consequence of | of): | | | | | |
| ed ssit | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of | of): | | | | | |
| executed ian and ial - transi | dical | UNPENDED | AMENDED | | : | | | | |
| sici pe | | IF FEMALE: | 23c. If yes, outcome of preg | gnancy | | | | 23d. Date of de | ivery |
| 68760, certificate be nding physici ise as the buri | ian/I | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | 2 Feta | | Ectopic pregnand | су | Month | Day Year |
| Box 6876 e death certificate the attending phy ed for use as the b | Physician/M | 1 Yes 2 No 9 Unknow | | eath 5 Othe | (Specify) | | | | |
| 0 - 0 | | Part II. Other significant conditions | contributing to death but not r | resulting in the un- | derlying cause give | n in Part I. | | | e to the cause of death? |
| 80 90 P | ad by | Diabetes mellitus | | | | | | | Probably 4 🗹 Unknown |
| cords, I aw requires nas been sig 2 should be | plet | | | | | | 24a. Was ar autops | prio | re autopsy findings available r to completion of cause of |
| Rec The la icate h | Completed | | | | | | perform 1 Yes 2 | | Yes 2 No |
| Vital ysician: | Be | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 |] 50(0.4 | C Oth | Death (Check on | | esidence 6 🗸 | Dh C |
| of V g Phys her this | <u>1</u> | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of Injury | ER/Outpatient 28b. Time of Inju | | | | w injury occurred | orner: Scerie |
| | tion | 1 Natural 5 Pending | (Month, Day, Year) | | 1 Yes | 2 No | | | |
| Division of Vital Records, pital or Attending Physician: The law require ourst after decora. After this certificate has been si filled in by the funeral director, page 2 should be | Certification: | 2 Accident Investiga 3 Suicide 6 Could no | t be 28e. Place of Injury - At h | ome, farm, street, | factory, office build | ding, etc. 2 | 8f. Location (Str or Town, Sta | | r Rural Route Number, City |
| Dispital hours and reful | Cer | 4 Homicide determine | (Opcony) | | | | | | |
| Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: | Medical | (Check only | cian: To the best of my knowled er:On the basis of examination a | - | | | | | |
| To To Com | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. License nu | | | 29d. Date signed | |
| (W | | Adh Brail | 4,00 | | O.C.M.E | E. | | July 11, 2012 | |
| 511 | | 30. Name and address of person who | | | | | | | |
| | | | Assistant Medical Exami | | Baltimore Stre | et, Baltimore | , MD 21223 | | |
| St | ate | 31. Date filed (Month, Day Year) | 52. Registrars Signat | Le de | / | | | | |

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 0^{Month} Day 09 2012a 5:12 A M Barbara Allen Braxton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Capitol Heights Ritas Adult Living . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours **Director** 579-42-7746 80 1 □ M 2 🗓 F 12/15/1931 Washington, DC Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince George's Aldephi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20783 1903 Elton Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. item 27 is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 💢 Divorced Specify: Black Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DC Government Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gladys Fuller Eugene Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Oliver Street Riverdale, MD 20737 Robert Braxton /Son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of P Important: If ite any injury or oth once. 20c. Location - City or Town, State cemetery, crematory or other pla Lincoln Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD Signatur 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 ast the attending for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law certificate has page 2 autopsy perform death? Yes 2X No 1 Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Hospital: 2 X No P within 24 hours after useru.

To the Funeral Director: After this of the funeral diffied in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53235 07/13/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darryl Hill 13635 Baltimore Avenue Laurel, MD 20707

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 13^{Day} Landletter 2012 Blackshear 6:25a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 06 15 21 267-52-0356 Director 91 1 □ M 2X□ F SC Show 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f MD NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5711 Gist 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>۾</u> 1 Yes : 2 💢 No 1 ☐ Yes 2 ☐XNo Specify: Specify: Black Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4th grade Housekeeping Stella Maris Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elliott Smith Kate Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Ross-Daughter 5711 Gist Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. 7/20/2012 Crownsville, 21. Signature of Funeral Service License March F H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a leart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death STOMACH CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has ☐ Yes 2 🗙 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE Certificate: To 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Division neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and liftle of certifie 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

1 6 2012

a.m.

2012

BLACKSHEAR

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | for State of Mar | | | | lental Hy | giene | | | |
|--|--|--------------------|--|---------------------------------|---|---|-------------------------------------|------------------------------|-------------------------|-------------------------------|----------------|
| Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death 3. The of Death | | | | | | | | | | | |
| | Physici Medi | | Josephine Rita Blusiewi | CZ | | | | 10 ^{Day} 201 | Year | 3. Time of I | |
| lie | Exami | | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or | Location of Death | July | 4c. County | | _0.00 | TA. |
| 2 | Ж | м | Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age //n | | Timon | | | | imo | _ | |
| | Funeral Director | | 214-18-9156 1 D M 25%F | yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birtl (Month, Day | (, Year) | | lace (State or ry) | |
| | d tt | _ | Usual Residence of Decedent | c. City, Town or Loc | | | Mar28 | ,1922 | | yland | |
| | larylan 3a-fsh ified a | Director | Md. | Baltimo | | ** | | | 10 | od. Inside City | |
| | the Manual or 28 | | 10e. Street and Number | Darcino | 10f. Zip Code | у | | 10g. Citizen of W | hat Count | | 2 140 |
| | th with ms 23: | Funeral | 5408 Plainfield Avenue | | 2120 | | | U.S.A | | | |
| ço | er dea' or iter niner | | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married | in U.S. 13. W | as Decedent of Hi Yes, specify Cuba | spanic Origin? (Spe n, Mexican, Puerto I | cify Yes or No- Rican, etc.) | | - America , White, e | | |
| 003 | urs afte ural", Il Exar | ted b | 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. | 1 | ☐ Yes 2X No | Specify: | | Specify: | Whi | te | |
| a.m. 15-00 | 72 hou n "nat fedica | nple | 15. Decedent's Education (Specify only highest grade completed) | (Give ki | ent's Usual Occup and of work done o | ation Juring most of working | ng | 16b. Kind of Bus | | , | |
| 8:06 a.m. nd 21215-0036 | within giene. er tha | To Be Completed by | Elementary/Secondary (0-12) College (1-4 or 5+) | | NOT use retired) | | | Archbis High So | | | еу |
| 8: Ind | e filed tal Hy ed oth event | o Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | (First, Middle, I | | 71.00 | _ | |
| 2012 8: Maryland | ould be d Men marke matic | - | James Kaliszak 19a. Informant's Name/Relationship (Type, Print) | | | Julia | | | | | |
| | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 3 | Thaddeus Blusiewicz / So | n 5408 | Address (Street a Plainf | ind Number or Rura ield Ave | Route Number, enue B | City or Town, Sta altimor | ite, Zip Co :e,] | Md . 21 | 206 |
| IULY 10, Baltimore, | ie 1 an tof He If item or othe | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State | Ob. Place of Dispos | ition (Name of | July | ate | 20c. Location - 0 | City or Tov | n, State | |
| .Y | iit. Pag artmen ortant: njury | 1-3 | 4 Donation 5 Other (Specify) | t.Stani: | slaus C | $em \mid 13,2$ | | Baltimo | | | |
| JULY Balti | Depar Impo any ir | - 1 | 21. Signature of Funeral Service Licensee MUU 9 3 | | Name and Addres 201 Dun | s of Facilit Kaca dalk Ave | enue Ba | kı Fune altimor | erai e, I | ноте Md.21: | , P. A. 222 |
| | | | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | death. Do not enter | the mode of dying | , such as cardiac or | respiratory arre | est, | | Approximate Interval Betwe | en en |
| | Physician Medical | 8 6 | Immediate Cause (Final disease or condition resulting in death) ################################### | | | | | | | Onset and De | |
| | Examiner | | Due to (or as a cor | nsequence of): | | | | | | | |
| 9.00 | p # | niner | Sequentially list conditions, if any leading to home detections, the conditions of t | icaqua ita ut;: | | | | | | | |
| 17/07 | xecute n and al-trans | Exan | Cause (Disease or injury that initiated events c. Due to (or as a cor | nsequence of): | <u> </u> | | <u> </u> | | - | | |
| EWICZ | te be e lysiciar he buri | dical Examiner | d | | | | | | | | |
| ST1 | ertifical ling ph | | IF FEMALE: | | | | | | | | |
| Box 687 | atth ce attenc | ician | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 23c. If yes, outcome of properties in the past 12 months? 1 ☐ Pregnant at time | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date Mont | | / lav Yea | ar |
| HINE P.O. B | t the di by the stached | Physician/Me | 9 ☐ Unknown | | | | | | | | |
| JOSEPHINE cords, P.O. I | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | ρ | Part II. Other significant conditions contributing to death but no | t resulting in the und | derlying cause give | en in Part I. | | acco use contrib | | . 1 | |
| OSE ords | requir been should | Completed | | | | | 24a. Was ar | es 2 No 3 | | y findings ava | iknown |
| Rec | The lav ate has page 2 | Somp | | | | | autops perform | y pri- ned? de: | | oletion of cau | |
| ta | ician: Sertific ector, | Be | 25. Was case referred to medical examiner? Hospital: | | | ce of Death (Check | | Z A NOT TE | _ 162 Z | _ 140 | |
| of Vi | r this c | 2 : | 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient: 27. Manner of Death 28a. Date of injury | 2 ER/Outpatient 28b. Time of | 3 DCA Other | 4 ☐ Nursing Hom | | | Specify) | HOSPI | CE |
| on (| ending eath. or: Afte he fun | ficat | 1 ☑ Natural 5 ☐ Pending (Month, Day, Yea 2 ☐ AccidentInvestigation | r) injury | work? | | od. Describe nov | w injury occurred | | | |
| JOSEP Division of Vital Records, | or Atte | Certificate: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp. | At home, farm, stree | t, factory, office | 2 | Bf. Location (Str. City or Town, | eet and Number of State) | or Rural Re | oute Number, | |
| | spital hours a neral [| ledical (| 29a. Certifier 1 Certifying Physician: To the best of my ki | nowledge, death oc | curred at the time. | date and place, and | I due to the equi | co(a) and manner | ac etated | | _ |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans | ≥ | only one) 3 Certifying Nurse Practitioner: To the best | ation and/or investio | ation in my opinion | donth accurred at the | o timo data ana | I place and due to | Al | /=\ == al == ==== | er stated. |
| | 5 Wit | | 29b. Signature and title of certifier | 120 | 29c. License | number | 25 | 9d. Date signed (I | nonth, Pa | v, Year) | , |
| | 0, | 1 | 10. Name and address of person who completed cause of death (| Item 23a) (Type, Prir | nt) | 10010 | <u> </u> | -7// | 0/0 | XOID | >- |
| | 1 | 2 5 | 4 Data Claude H D W | DULANEY | VALLEY R | D. TIMON | IUM, MD | 21093 | | | |
| | Stat Registra | - | JUL 1 6 2012 2: Registrar's Si | S. par | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Month 12^{Pay} Physician/ 2012 8:41 P Juanita Smith Clemont Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 77 Director 223-40-5320 1 □ M 2 XX 04/25/1935 Virginia Usual Residence of Dece 28a-f shov 10b. County ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DC None Washington 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 915 Ridge Road S.E. 20019 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Specify: Black ģ 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Government years Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred Smith Mary Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2351 Skyland Terrace S.E. Washington, DC 20020 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is: Linda Clemont/Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date crematory or other place. 1 X Burial 2 Cremation 3 Removal from State Cedar Hill 07/20/2012 |Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home <u>4308 Suitland Road Suitland, MD 20746</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last burialattending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day ned by the at detached for Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? After this certificate I 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes မ Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural Natural 5 Pending Accident 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

within 24 hours after death

To the Funeral Director: / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signa 29d. Date signed (Month, Day, Year) 20/2 lame and address of person who completed cause of dea em 23a) (Type, Print) 32. Registrar's Signature State 1 6 2012 Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:29 race Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burnie 8. Date of Birth (Month, Day, Year) Security Number Birthplace (State or Foreign Country) **Funeral** Min. 241-38-5529 Director 1 **X** M 2 □ F 90 S.C 12-18-1921 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director Severn 1 Yes 2 No 5 10e. Street and Nur 10f. Zip Code 10g. Citizen of What Country? 23a 211 44 USA 0 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural" Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than condary (0-12) College (1-4 or 5+) arounds mai other traumatic event, Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maide and Mental is marked o ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra 904 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State rownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_ysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 2 No Yes 2 No 1 Yes Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signatur rson who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 18, 20a-c, 22, per me, g929 7-24-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 03248 a mes 2017 Medical 4a. Facility Name (if not institution, give street **Examiner** of Death O s Kowa OW a **Funeral** 7. Age (In yrs. last bi 9. Birthplace (State or Freign 8. Date of Birth (Month, Dav. Year) Hours 94 **Director** 446-09-7622 1 🛣 M 2 🗆 F Usual Residence of Decede May 6, 1918 Ohio 10a. State 10b. County the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 No MD Montgomery Silver Spring ō 10e Street and Number 10f. Zip Code ms 23a o 10g. Citizen of What Country? Funeral with 1 20903 USA 8537 11th Avenue items (death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or item ledical Examiner ה 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 👿 No Specify. black Completed 3 ♥ Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Department of Housing 12 housing inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be firt of Health and Mental ည James Henry Dotson Sr. Rebecca Travillion Trevillion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8537 11th Avenue; Silver Spring, MD 20903 Department of Health Important: If item 27 any injury or other t Cecelia Beharry-Hall – caregiver Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Crema 4 ☐ Donation 5 🛣 Ou on 3 Removal from State (Specify) **In State** Chesapeake Crematory 7/20/12 Beltsville,MD State Anatomy Board PO Box 1413 Cremation Services Baltimore, MD Ronald S 22. Name and Address of Facility State Anatomy Board 655 Wasyland Cremation Services Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) (or as a consequence of) Examiner Mkuau Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 No page 2 should be detached been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: 욘 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of cer 29c. License number

State Registrar Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $11^{\!\text{Day}}$ Physician/ Menth 2012 12:45 Rose Sandler Greenberg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min **Director** 214-82-0160 95 1 🗆 M 2 🔀 F Virginia 8-22-1916 Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Rockville Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20852 United States 5750 Bou Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify: "natural" 3 X Widowed 4 Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental Morris Sandler Sarah other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 5108 Clavel Terrace, Rockville, MD 20853 Morton Greenburg - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Beth Tfilo 7-13-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility S^{see} Edison Perkins 21. Signature of Funeral Service Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 LOSTO OF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pulmonary Edema Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Severe Aortic Valve Stenosis and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical SC Greenberg 07/11/ Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth ∠☐ recall.
☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 Ø No Month Day Year signed by the at Id be detached fo g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 🗌 No Yes 2 N the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 056 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 66264

DHMH 17 Rev 06-2011

State Registrar egistrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babak Salehi Pirouz

31. Date filed (Month, Day, Year,

07/1/ /12

| 0 | 0.1 | 0 | 0 | 0 | 2 | 2 | |
|---|-----|---|---|---|---|---|--|
| 2 | J I | 6 | 2 | 6 | 0 | J | |

| | 1- For State Registrar | Certifi | icate of Death | Reg. I | No. | 5.4 1.00 |
|--|--|--|--|--|---|--|
| Physician/ Modical Examine | Decedent's Name (First, Middle Andrew Gold | | | 2. Date of Death Month Da June 25, 201 | av Year | Time of Death 1037 hrs |
| | 4a. Facility Name (if not institution 46200 Sylvan Court | on, give street and number) | 4b. City, Town, or Location of Dea Lexington Park | th | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 224-47-2607 | 6. Sex 7. Age (In yrs. last b | oirthday) If Under 1 Year If Under 24H Months Days Hours Mi Yrs. | | MM/DD/YYYY) 9. Birthpla Foreign 1973 Countr | ace (State or y) France |
| <u>k</u> r | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tov | vn or Location | | 110 | d. Inside City Limits |
| ryland a-f show any t once, ctor | MD st. | Mary's Co | Lexington Park | | 1 | Yes 2 XNo |
| the Maryland 3a or 28a-f sh otified at ouc | 10e. Street and Number 46200 Sylva | n Ct. | 10f. Zip Code 20653 | | Citizen of What Country? | ? |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 1 Never Married 2 N 3 Widowed 4 Di | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No vorced If Yes, Give Year | 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 X No specify: | | 14. Race - American White, etc. Specify: Whi | |
| nours aft | 15. Decedent's Education (Spe | | a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re | | h Kind of Business/Indu The Associ | stry ated |
| 5-0036 led within 72 hour led within 72 hour Hygiene. I other than "natu the Medical Exam Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) 4 years | Journalist | , | Press | |
| y, MD 21215-0036 and 2 should be filed within 72 hours after tealth and Mental Hygiene. ten 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by | 17. Father's Name (First, Middle Michael Gol | dsmith | 18 Mother's Nam unk | ne (First, Middle, Maid Gold | den Surname) dsmith | |
| MD 2121 d 2 should be fi lth and Mental 1 n 27 is marked numatic event, To Be | 19a. Informant's Name/Relation: Roxanne Sum | | 19b. Mailing Address (Street and Number or 46200 Sylvan Ct., | | | |
| ore, I and stand of Healt If item | 20a. Method of Disposition 1 Burial 2 Crematio | crem | e of Disposition (Name of cemetery, latory or other place) site Crematory | Date 20 | Oc. Location - City or Tow Baltimore, | n, State |
| Baltimore, permit. Pages 1 an Department of Hea important: I free impertant: If itee injury or other tr | 4 Donation 5 Other S 21. Si nature o Funeral Service | Specify: | 子的是即任他的 婚子的 No Fulton | Jr. Fune | | |
| Physician | 23a. Por I. Enter the Jease, o | r complications that caused the death. Do | not enter the mode of dying, such as cardiac | | shock, or heart A | MD 21217 pproximate Interval Between Onset and |
| /Medical Examiner | Immediate Cause (What disease or condition resulting in death) | Due to (or as a consequence of): | | | | Death |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | b. Due to (or as a consequence of): | | | | |
| ted Insit | (Lieute or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | 492_20 | | |
| execur an and al - tra | UNPENDED | d AMENDED | | - | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burification: To Be Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un | 23c. If yes, outcome of pregnand he 1 Live birth 4 Pregnant at time of death 9 Unknown | cy 2 Fetal death 3 Ectopic pregr 5 Other (Specify) | | 23d. Date of delivery Month Day | Year |
| , P.O. I res that the signed by the be detached by the bed by the bed by the bed by Pk | Part II. Other significant condi | tions contributing to death but not result | ing in the underlying cause given in Part I. | | cco use contribute to the | |
| Records, The law requires fitcate has been signage 2 should be Completed | | | | 24a. Was an autopsy performed | prior to comp d? death? | by findings available oletion of cause of |
| tal Rectinar: The Certificate Sector, page | 25. Was case referred to medical | al | 26.Place of Death (Check | 1 Yes 2 | No 1 Yes | 2 No |
| f Vital Physician Tribis certi ar this certi To Be | examiner? 1 ✓ Yes 2 No | Lle enitels . | Othor - | | sidence 6 Other: Sc | ene |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P | 27. Manner of Death 1 Natural 5 Pen | ding FOUND: Day, Year) FO | o. Time of Injury DUND: 15 hrs 28c. Injury at Work? 1 Yes 2 ✓ No | 28d. Describe how Subject hanged | | |
| Division o' Hospital or Attending; 24 hours after death. Funeral Director: Afte | 3 ✓ Suicide 6 Cou | | farm, street, factory, office building, etc. | or Town, State | et and Number or Rural F e) ourt, Lexington Park, N | |
| To the Hospi within 24 hou To the Fune completely fi | 29a. Certifier (Check only) Certifying P | aminer: On the basis of examination and/o | death occurred at the time, date and place, an or investigation, in my opinion, death occurred | | | use(s) |
| Me S P S P S | 29b. Signature and title of certifi | and manner stated. | 29c. License number | 29 | 9d. Date signed (Month, | Day, Year) |
| 1841 | () (bode | rul) | O.C.M.E. | J | une 26, 2012 | |
| . p. | | n who completed cause of death (Item 23a Assistant Medical Examiner 90 | o) 00 W. Baltimore Street, Baltimore, | MD 21223 | | |
| State Registrar | | 32. Registrar's Signature | , | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For Sta | te of Maryland / Depa | artment of Hea | Ith and Menta | I Hygier | ne | |
|----------------------------|--|--------------------------|---|--|---|---|----------------------|-------------------------------------|--|
| | | | State Registrar | Cer | tificate of Dea | ath | Reg. | No. 201 | 2 22332 |
| | Physicia | n/ | Decedent's Name (First, Middle, Last) Tox | vel Marie Hill | | Mon | of Death | Day Year 2012 | 3. Time of Death |
| Marian | Medic | | 4a. Facility Name (if not institution, give street ar | | 4b. City, Town, or Loca | | | | 10:25 PM |
| لمسا | Examin | er | St. Theresa's | u number) | Laurel | ation of Death | - 1 | 4c. County of De | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year If U | Jnder 24 Hrs. 8. Date | of Birth | Prince G | irthplace (State or Foreign |
| | Director | | 428-34-4325 1□M2 | X F 84 Yrs. | Months Days Ho | ours Min. (Mor. | nth, Day, Yea | r) C | ountry) |
| | T OM | | Usual Residence of Decedent | | | Jun | e 11, | L928 Mi | ssissippi |
| | yland -f sho ed af | ctor | 10a. State 10b. County | 10c. City, Town or Loc | cation | | | | 10d. Inside City Limits |
| | e Maı r 28a notifi | Director | MD Prince Georg | e Laurel | Tank 75 Oct | | | | 1 🗌 Yes 2 🛣 No |
| | ith th | | | | 10f. Zip Code | | | Citizen of What C | Country? |
| | ath w | Funeral | 16013 Kenny Road 11. Marital Status 12. Was | Decedent Ever in U.S. 13. V | 20707 Vas Decedent of Hispan | ic Origin? (Specify Yes | or No- | 14. Race - Am | perican Indian |
| 21215-0036 | is filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by | 1 Never Married 2 Married 1 If Ye | ed Forces? If | | exican, Puerto Rican, et | | Black, Whi | ite, etc. |
| 0-10 | hours natur lical | Completed | 15. Decedent's Education | 16a. Deced | ent's Usual Occupation | | 16b | . Kind of Business | · · · · · · · · · · · · · · · · · · · |
| 218 | in 72 e. nan " | duic | (Specify only highest grade comp Elementary/Secondary (0-12) Coll | | ind of work done during NOT use retired) | g most of working | | | · |
| 2 | iled within 72 Il Hygiene. other than ' vent, the Me | | | 4 Nurse | | | H∈ | ealth Car | re |
| Maryland | e filed ital Hyg ed oth event | To Be | 17. Father's Name (First, Middle, Last) | | | Mother's Name (First, N | -, | | |
| 7 | should be file and Mental h is marked o raumatic eve | | John Rufus Keith | | - | Chlotilda S | | | |
| Mai | | | 19a. Informant's Name/Relationship (Type, Print | I | | lumber or Rural Route N | , , | | Zip Code) |
| e, | and Heali tem | 3 | Mary Kathryn Childer 20a. Method of Disposition | 3/daughter 1601 20b. Place of Dispos | | d, Laurel, | | 7 0 7 . Location - City o | or Town State |
| Baltimore, | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. | | 1 ☐ Burial 2XXCremation 3 ☐ Remova | il from State cemetery, crem | natory or other place) | July 13 | , | • | |
| ij | artme ortar injur | 3 | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee | | ndel Crem. | 2012 Facility Donald: | | enton, MI | |
| ñ | permir Depar Impor any ir once. | | J. Kein Skiles | | | Ave., Lau: | | | ome, P.A. |
| п | - 1 | | 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause | that caused the death. Do not ente | | | | 20,0, | Approximate |
| | Pnysician/ | 02 4 | Immediate Cause (Final | | | | | | Interval Between Onset and Death |
| - | Medical | | regulting in death) | oronary Artery D: ue to (or as a consequence of): | Isease | | | | Years |
| | Examiner | <u>.</u> | Sequentially list conditions, b. | | | | | | |
| | d sit | Examiner | if any, leading to immediate D cause. Enter Underlying | ue to (or as a consequence of): | | | | | |
| | ecute and I-tran | xar | Cause (Disease or injury that initiated events c c | ue to (or as a consequence of): | | | | | |
| _ | ate be executed physician and the burial-transit | dical | | , | | | | | |
| 760 | icate physis the | ω . | d | | | | | | |
| 99 | eath certifica attending p | J/N | | es, outcome of pregnancy | | | | 23d. Date of d | elivery |
| Box 687 | death e atte | sicia | 1 Yes 2XXVo | | Other (specify) | | | Month | Day Year |
| o. | t the c by th | Phys | 9 LJ ONKNOWN | Unknown | | | _ | | |
| , P.O. | requires that the dec been signed by the s should be detached | Completed by Physician/M | Part II. Other significant conditions contributing | g to death but not resulting in the ur | nderlying cause given in | Part I. 23e. | | | to the cause of death? |
| rds | een si | eted | | | | | 1 L Yes | 2 ∐ No 3 ∐ I | Probably 4xxUnknown |
| Division of Vital Records, | has b | uple | | | | 24a | . Was an autopsy | prior to | utopsy findings available completion of cause of |
| æ | r; The la icate ha r, page | õ | | | | 1 🗆 | performed Yes 2XX | | es 2 KNo |
| ital | siciar certif irecto | m | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | | | f Death (Check only one Nursing Home 5 | / | | Assisted |
|) (| Physer this eral d | e: To | | 1 Inpatient 2 ER/Outpatient Date of injury 28b. Time of | t 3 L DOA 4 | | | 6xxOther (Spe jury occurred | cify) Living |
| on c | nding ath. :: Afte ie fun | icat | 1XX Natural 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day, Year) injury | work? M 1 ☐ Yes | | | ,, | |
| isic | er des ecto | Certificate: | 3 Suicide 6 Could not be 4 Homicide determined 28e. | Place of Injury - At home, farm, stre building, etc. (Specify) | et, factory, office | | | | ural Route Number, |
| Ö | ital or irs aft al Dir lled in | | 10 11 | building, etc. (opcony) | | Oity | or Town, Sta | iie) | |
| | To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Medical | (Check 2 Medical Examiner: On t | the best of my knowledge, death on the basis of examination and/or investi | gation, in my opinion, de | ath occurred at the time, | date and pla | ice, and due to the | cause(s) and manner stated. |
| | o the rithin 2 o the comple | | only one) 3 L Certifying Nurse Practi 29b. Signature and title of certifier | tioner: To the best of my knowledge, | death occurred at the tim 29c. License num | · · · · · · · · · · · · · · · · · · · | 1 | use(s) and manner Date signed (Mon: | |
| | F S F ŏ | | PORman | non | D23181 | | | | |
| | 35 | | 30. Name and address of person who completed | cause of death (Item 23a) (Type Pi | | | 1 00 | ly 10, 2 | .012 |
| | | | R.G. Bhojraj, MD, 704 | Gorman Ave., Su | uite Tl, La | urel, MD 20 | 707 | | |
| | Stat | е | 31. Date filed (Month, Day, Year) 2012 | 32. Registrar's Signature | Les . | | | | - |
| | Registra | ır | JULIO COIL A | Mary Land | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0840 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Denison street NA hmore If Under 8. Date of Birth (Month, Day, **Funeral** . Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Davs Director 578-42-1844 1 M 2 F 8 02-05-24 MD show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director or 28a-f sh notified a NA Baltimore 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 615 N. Denison Street 21229 **USA** Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 11. Marital Status 14. Race - American India Black, White, etc. African Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Specify: American Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States other than Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Book Binder Gov. Printing Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever မ Denmark Esther Ernest Denmark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Maxine Price-Daughter 724 Milyer Lane Baltimore, Maryland 21229 : If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State Department of Important; If any injury or 07-19-12 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemeterv Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie_Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) Medical Due to (or as a con a quence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due resulting in death) Last as a consequence of): signed by the attending physician dbe detached for use as the buria Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Vear Pregnant at time of death Inknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Tyes 2 3 MG ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) sompletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation 1 \sum Yes 2 🗌 No 3 Suicide
4 Homicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Day, Year) 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Me MO State 32. Registrar's Sign JUL 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 125 ohnson Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Richey Baltimore oseph Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 219-50-0648 Director 1 **X** M 2 □ F 64 3-1948 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: if Item 27 is marked other than "natural", or Items 23e or 28a-f show emphyliumy or other treumatic event; the Machael Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Honore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates Specify Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) /Secondary (0-12) onstruct Employ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD 21212 Inomasine 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tal Physician adenocarcinoma Johnson 60 ase or condition syears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transi and Due to (or as a consequence of): resulting in death) Last attending physicien Physician/Medical the Hospitei or Attending Physician: The law requires that the death certificate be Jusaph Division of Vital Records, P.O. Box 68760 the use es 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ؤ in the past 12 months? Month Day 5 Other (specify) Year ☐ Yes 2 ☐ No be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate hes been siç ; page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ဂ္ 1 Tyes HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) C 17.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltsmore MD Standiford HOSPICE tarold Juseph SCL 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 17^{Day} Month 06 Physician/ 201^{Year} 3:20 A M Elizabeth Kittredge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** District Heights Prince George's 2401 Boones Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year, Hours Months 578-42-3946 87 1 □ M 2 🗓 F **Director** Yrs 08/24/1924 North Carolina 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location the Maryland Director Examiner must be notified 1

Yes 2 □ No MD Prince George's District Heights 10f. Zip Code 109. Citizen of What Country? ö 10e. Street and Numbe 23a Funeral 20747 USA 2401 Boones Lane or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify. Caucasian 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed or other traumatic event, the Medical Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) ye 1 and 2 should be filed within 7, t of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Private Waitress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jesse Brown Bonnie Barwick ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Boones Lane District Heights, MD 20747 Bobby Daniel/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 07/16/2012 Suitland, MD Washington National Donation 5 Dother (Specify) 22. Name and Address of Facility Marshall-March Funeral home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical The law requires that the death certificate be P.O. Box 68760 as IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the at d be detached fo 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 1 Yes 2 No 3 Probably W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed has certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. It 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 2 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifing Yurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar e of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatur

Bahram Pishdad 1328 Southern Ave. SE Washington, DC 20032

32. Registrar's Signature

29c. License number

D 51520

29d. Date signed (Month, Day, Year)

06-22-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Bernice W. Kuehl 12:15 P M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 6302 South Orchard Road Linthicum Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) Director 342-16-6900 89 August 28, 1922 Illinois Usual Residence of Decedent 28a-f show 10d. Inside City Limits ŧ 10a. State 10b. 10c. City. Town or Location Director Anne iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Linthicum Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 6302 South Orchard Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes 2 😿 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White "natural", 3 X Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Carvski traumatic John Witort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Ann Zavorka/Daughter 6302 South Orchard Road, Linthicum, Maryland 21090 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Clarendon Hills 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cemetery Darien, Illinois 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, M01386 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on such line. Immediate Cause (Final Orthor and Realth /-Promisian/ disease or condition Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying MONT Exami burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 month Month Day Year Pregnant at time of death the be detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has this certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifice funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending atural work?
1 Yes 2 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and t

Registrar

State

31. Date filed (Month, Day, Year)

6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 2

| | | 1 | For State of Ma | | irtment of Health and tificate of Death | | leg. No. 2012 22337 |
|--------------------------------|---|------------------|---|--|--|--|--|
| | Physicia | | 1. Decedent's Name (First, Middle, Last) KATHERINE KOCH | | | 2. Date of Deat Month | Day Year |
| | Medic Examin | al - | A. Facility Name (if not institution, give street and number) | | 4b. City, Town, or Location of Dea | JULY ath | 09 30/2 /6:28 M 4c. County of Death |
| | _xamiii | | HARBOR HOSPITAL | | BALTIMORE | | N/A |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age 1 M 2 F | (In yrs. last birthday) 91 Yrs. | If Under 1 Year If Under 24 Hr Months Days Hours Mir | | Year) Country) |
| | | I. I | Usual Residence of Decedent 10a, State 10b. County | 10c. City, Town or Loc | eation | | 10d. Inside City Limits |
| | arylanda-fsh ifieda | ecto | Maryland Baltimore | Baltimo | | | 1 ☐ Yes 2 🙀 No |
| | the M a or 28 se noti | ä | 10e. Street and Number | | 10f, Zip Code | | 10g. Citizen of What Country? |
| | th with ms 23a must I | Funeral Director | 4402 Annapolis Road | iver in U.S. 112 W | 21227 Vas Decedent of Hispanic Origin? (| Specify Yes or No- | U.S.A. |
| 920 | e fied within 72 hours after death with the Maryland that hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates. | No. | Yes, specify Cuban, Mexican, Pue | rto Rican, etc.) | Black, White, etc. Specify: White |
| 2-0 | 2 hour "natu edical | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give F | ent's Usual Occupation kind of work done during most of w | orking | 16b. Kind of Business Industry |
| 7121 | within 7 giene. ner than t, the M | | Elementary/Seconday (0-12) College (1-4 or 5 | +) | NOT use retired) Spector | | Western Electric |
| Baltimore, Maryland 21215-0036 | filed vial Hyg d othe | To Be | 17. Father's Name (First, Middle, Last) | | 18. Mother's N | ame (First, Middle, M | Maiden Surname) |
| ryla | should be file and Mental is marked of raumatic eve | ٦ | John Macks 19a. Informant's Name/Relationship (Type, Print) | | IYI. | ary Kliss | City or Town State Zip Code) |
| Ma | ~ ± 73 ∃ ~ | | Jack Saley / son | | Annapolis Road | | more, Maryland 21227 |
| ore, | | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State | | natory or other place) | Date | 20c. Location - City or Town, State |
| tim | Par ant ury | 4 | 4 ☐ Donation 5 ☐ Other (Specify) | | | | Elkridge, Maryland |
| Ba | permit. Departr Import any inji | Į. | 21. Signature of Funeral Service Licensee | | | | eral Service, P.A. cimore, Maryland 21225 |
| | | | 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line | ÷. | | | Interval Between |
| and . | Physician/ Medical | i | a. a. a. a. a. a. a. a. a. a. a. a. a. a | ts SECON | DARY TO PNE | EUMONI | 4 Onset and Death |
| | Examiner | | Due to (or as | a consequence of): | | | |
| | n # | Examiner | cause. Litter Universiting | a consequence of): | | | |
| 77 | kecuter and al-trans | Exan | Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as | a consequence of): | | | |
| δ, Λ, | cate be executed physician and the burial-transit | edical | d | | | | |
| 3876 | ertificat ding ph | | IF FEMALE: 23c. If yes, outcome | of pregnancy | | | 23d. Date of delivery |
| . Box (| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M | 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown | 2 ☐ Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | Month Day Year |
| P.0 | that the | | Part II. Other significant conditions contributing to death to | out not resulting in the u | inderlying cause given in Part I. | 1 | bacco use contribute to the cause of death? |
| rds, | equires een siç | eted | CORONARY ARTERY DISE | 30 3/1 611 | | 1 🗆 Y | res 2 	No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available |
| eco | ne law r e has b age 2 sl | Completed by | FALCENSION | | | utop = 24a. was a autop perfor 1 □ Yes | prior to completion of cause of med? death? |
| tal F | sian: T ertifica ctor, p | Be C | 25. Was case referred to medical examiner? | | 26. Place of Death (C | | |
| Ž | Physic this or | 은 | 1 ☐ Yes 2 ► No Hospital: 1 ► Inpat 27. Manner of Death 28a. Date of inju | ient 2 ER/Outpatier | | | ence 6 Other (Specify) ow injury occurred |
| o uc | nding ath. r. After ie fune | icate | 1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ AccidentInvestigation | y, Year) injury | work? M 1 ☐ Yes 2 ☐ No | | |
| Division | al or Atte s after de al Directo ed in by th | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, et | ury - At home, farm, str c. (Specify) | eet, factory, office | 28f. Location (S City or Tow | treet and Number or Rural Route Number, n, State) |
| _ | Hospit 24 hour Funera sted fille | Medical | | examination and/or inves | tigation, in my opinion, death occurr | ed at the time, date ar | nd place, and due to the cause(s) and manner stated. |
| | To the within To the comple | Σ | only one) 3 \square Certifying Nurse Practioner: To the 29b. Signature and title of certifier | best of my knowledge, | 29c. License number | | 29d. Date signed (Month, Day, Year) |
| | | | MD mo | | RES 000 | | JULY 09 2012 |
| | 5 | | 30. Name and address of person who completed cause of a SOUTH HANOV | death (Item 23a) (Type, I | Print) NAVARATNA | RAJAH | 21225 |
| | Sta | | 31. Date filed (Month, Day, Year) 2012 32. Registr | ar's Signature | w/ | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh g929 7-27-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TÔ 2ÕÏ2 19:02 Stephen Maxwell Lebby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month. Dav. Year) Months Davs Hours Min 272-40-4447 67 1**X** M 2 □ F Director 10-28-1944 Cleveland, Ohio Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 X No North Bethesda MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5801 Nicholson Lane 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner rmed Forces? Vietnam If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Era White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Packaging, Medical Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ပ Harriet Siegel Leonard B. Lebby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 619 Warfield Dr., Rockville, Maryland 20850 Jonathan Lebby - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o oonce. 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 7-13-2012 Clarksburg, Maryland 4 Donation 5 Other (Specify) Signature of Euneral Service Lice 22. Name and Address of Facility Edward Sagel Funeral Direction Brjan Deibler 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Amyotrophic Lateral Sclerosis Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury pue to for as a consequence on Anemia been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d, Describe how injury occurred work?
1 Yes 2 No 1X Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral C Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Fractitioner: To the best of my knowledge, death d at the time, date and place, and due to the 29c. License number 29d. Date signed (Month, Day, Year) 7-11-2012 D0060117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Eric Park, MD -31. Date filed (Month, Day, Year) State 1 6 201 Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 PM ZOIZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death $\mathbf{D}\alpha$ If Under 1 last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 1 🗆 M 2 💢 F 83 Yrs Country) Director 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 ☐ No 10e. Street and Number 0 10g. Citizen of What Country? Funeral 23a items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOME Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, drughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ElizaBe YORK 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State OWINGS. 4 Donation 5 Other (Specify) orest uneral Service Licensee 21. Signatur 23a. Part 1. Enterthe dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure interval Between Onset and Death List only one cause on each line. Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or a la consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 in the past 12 months? Pregnant at time of death Month Day Year Other (specify) 1 L Yes 9 Unknown should be detached Unknown signed by 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No 25. Was case referred to medical Assisted the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2. No ၉ Living 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAROL ETTO 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink First Place All Copies Are Legible.

AMEND TITEM#10e, 19 b, perfil , G929, 7/26 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Harry Franchot Marine : 25AM Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-34-4081 Months Hours Min. 1**X** M 2 □ F 03 12 ear) Country) 73 39 **Director** MD Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** Examiner must be notified MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number Cottage 10g. Citizen of What Country? 21215 U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give 3 Divorced Specify: Year or Dates th and Mental Hygiene.
It is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) llth grade Truck Driver Self-Employed na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorethea Marine Charles Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Collage Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Anita Marine-Wife Cottage 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 7/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Owings Mills, 21. Signature of Fur Service Li Markand Addres of acility 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical ivision of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day tor: After this certificate has been signed by the a the funeral director, page 2 should be detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) within 24 hours a

To the Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated control in the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated control in the cause of th (Check 29b. Signature and title of certifier 056508 M .O. X/ANGRONG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BLV BLVD MOZIZ 2. Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 9:05 Claudia Frances Macdorman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 🗆 M 2 🗓 F Davs Hours 4-26-1931 81 **Director** 440-28-0693 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Takoma Park 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 8002 Maple Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates ð 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Acupuncturist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Hufnagel Clarence Lightner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 Maple Avenue, Takoma Park, Maryland 20912 Marian Macdorman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 7-16-2012 Falls Church, Virginia Kurt Blake 21. Signature of Funeral Service Lie 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ outheroscherotic heart disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Sees 2 No ၉ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After injury 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 3. rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Exaction or Totals U.S. total years of the time date on a place and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kamer D.V 10 6 7413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Karno 7400 Carroll Ave.

Registrar's Signature.

31. Date filed (Month, Day, Year)

Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Paul William Manos July 2012 6:02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3333 Sudlersville S. Laurel Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Director 025-14-3664 1 ★M 2 ☐ F 87 Yrs Jan. 30 1925 Florida Usual Residence of Decedent Show e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must he nofitied at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 3333 Sudlersville S. 20724 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. b 1 Never Married 2 X Married 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates al Hygiene. d other than "natura event, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Ø US Government Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Manos Daisy Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Manos/Wife 3333 Sudlersville S. Laurel, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State ± 5 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2012 West Arundel Crem. Odenton, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MDPart 1. Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given In Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimer's Disease, Carcinoid Syndrome 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Myasthenia Gravis s after death.

Director: After this certificate has autopsy performed? Yes 2 X No page 2X No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending XNatural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the pass of examination and/on investigation, in my special occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number Led men H37211 July 12, 2012

• 6M

Registrar

DHMH 17 Rev 06-2011

5450 Knoll North Drive, Columbia, MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Freedman

Marshall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year REME MACKLIN 158 PM 0 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltemore General Itospita ylan 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 0374471960 1 M 2 TyF 220-80-6117 Maryland **Director** 52 Usual Residence of Decedent 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 633 N. Aisquith St. 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 Xo Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Private Homes Nursing Aid Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grover Macklin Mazelle Bagby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27206 19a. Informant's Name/Relationship (Type, Print) Deborah Anderson(sister) 5461 Cedonia Ave., Apt C3, Baltimore, of Health 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) . Page 1 Burial 2 K Cremation 3 Removal from State permit. Page Department of on-site Crematory Donation 5 Cher (Specify) Baltimore, f Funeral Ser ignature Foreight Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD 21217 29a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or imputhat initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the buria **Medical** To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day ed by the a 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? signed I <u>Ş</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed History of Non-ST elevation this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗆 Nursing Home 5 🗔 Residence 6 🗀 Other (Specify) Hospital: 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town. State Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) MD 07/09/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zceshan land 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 22344

| | | 1- For State Registrar | | Certific | ate of | Death | _ | | Re | eg. No. | 20 | |
|---|-------------------|---|---|-----------------|--------------|---------------------------|--------------------|--------------|--|---|--------------------------|---|
| Physicia | an/ | 1. Decedent's Name (First, Middle, | | | | | | - 1 | 2. Date of Deat Month July 3, 20 | | Year | 3. Time of Death 1026 hrs |
| lical Exami | ner | Jimmy Tony M 4a. Facility Name (if not institution, | | Toney | | re o. City, Town, | or Location o | of Death | July 3, 20 | | nty of Death | 10201115 |
| | | 919 Mount Holly Street | | | | Baltimore | | | | 10.000 | N/A | |
| Funeral | | | 5. Sex 7. Age (I | n yrs. last bir | thday) | If Under 1 Y | | r 24Hrs. | 8. Date of Bir | th (MM/DD/Y) | (YY) 9. Birtl Foreigi | hplace (State or |
| Director | | 219-40-6540 | 1 XM 2 F | 66 | Yrs. | Months D | ays Hours | Min. | 12/30 | /1945 | Cou | intry) MD |
| ŕ | | Usual Residence of Decedent 10a. State 10b. County | 110 | c. City, Town | or Locatio | n | | | | | | 10d. Inside City Limits |
| 1 E E | | MD N/A | | | | altim | ore | | | | | 1 XYes 2 No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 11 | 0g. Citizen of | What Coun | itry? |
| th the Maryland 23a or 28a-f sho notified at once. | Dire | 919 Mt. Holle | y St. | | | | 212 | 29 | | Ü | J.S.A | • |
| n with ms 23 be no | eral | 11. Marital Status | 12. Was Decedent Ev | er in U.S. | | Decedent of I | | | ecify Yes or No | | ace - Americ | can Indian, Black, |
| r deatl | Funeral | 1 Never Married 2 X Mar | 1 Yes 2 X | No | | | | , r Borto t | 110011, 01017 | | - D | lack |
| irs afte | by | 3 Widowed 4 Divor | rced If Yes, Give Year or Dates: fy only highest grade comple | eted) 16a. | | Yes 2 X I s Usual Occu | | kind of wo | ork done | Speci 16b. Kind of | | |
| 5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | - | • | st of working I | | use retire | ed) | | | MD |
| within ene. | m | | 3 years | | HVAC | Mech | | | _ | | e of | MD |
| 15-(filed al Hyg ed oth | | 17. Father's Name (First, Middle, L Jimmy Dallas | • | | | | Į. | | First, Middle, M Wynn | Maiden Surna | me) | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shi natic event, the Medical Examiner must be notified at once | То Ве | 19a. Informant's Name/Relationshi | | 19 | b. Mailing | Address (Sti | | | ural Route Num | nber, City or T | Town, State, | Zip Code) |
| | | Gloria May Mo | ore(wife) | | | | | | | | - | 21229 |
| ore, ML es 1 and 2 s of Health at fritem 27 her traums | | 20a. Method of Disposition 1 X Burial 2 Cremation | 3 Removal from State | crema | tory or othe | | | | Date | i | on - City or | |
| | | 4 Donation 5 Other Spe | | Mt. | | Ceme | | | /09/12 | 1 | | re,MD |
| Balt permit. Depart Import injury | | 21. Signature of Juneral Service L | cenagee Co | ur | 250 221 | sephor 40 N. | Fult | wn i on A | Jr. Fu Ave., | neral Balti | . Hom more | e PA , MD21217 |
| Physician | | 23a. Part Enter the dist ase, or co | | e death. Do n | _ | | | | | | | Approximate Interval Between Onset and |
| /Medical Examiner | | fail ne. List only one cause o | _{a.} Hypertensive Athe | eroscleroti | c Cardio | vascular D | Disease | | | | | Death |
|) | | condition resulting in death) | Due to (or as a consequ | ence of): | | | | | | | | |
| \ | Jer | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequ | ence of): | | | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequ | ence of): | | | | | | | | |
| 760, Trate be executed physician and the burial - transit | | events resulting in death). Last | d | | | | | | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi | /Medical | UNPENDED | X AMENDED | ME.G93 | 1 9/1 | 14/2012 | NS WS | | | | | |
| 376C ficate g phys s the bi | | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, outcome | of pregnancy | <u> </u> | il death | 3 Ectopic | nreanan | cv | 23d. Date Month | e of delivery | ay Year |
| Box 68760, e death certificate be the attending physic ed for use as the bur | icia | past 12 months? | 4 Pregnant at tim | o of | | er (Specify) | | pregnan | | l l l l l l l l l l l l l l l l l l l | | rou, |
| Bo he dea y the a | Physician | 1 Yes 2 No 9 Unkn | 9 Unknown | | a in the co | deal de carre | a china la Da | -1 | 220 Did to | 100000000000000000000000000000000000000 | antributo to 1 | the cause of death? |
| P.O. es that the igned by be detach | ģ | Diabetes | ns contributing to death bu | ut not resultin | y in the un | derrying caus | e given in Fai | II I. | | | | ably 4 Unknown |
| Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Completed | | | | | | | | 24a. Was | | | topsy findings available |
| e law in the hast | du | | | | | | | | autop | | death? | ompletion of cause of |
| tal Rection: The certificate ector, page | | 25. Was case referred to medical | | _ | | 26.Pla | ace of Death (| Check or | | 2 110 | 1 Yes | 5 2 140 |
| Vita hysicia this ce | o Be | examiner? 1 ✓ Yes 2 No | Hospital: 1 Inpatient | 2 ER/0 | utpatient | 3 DOA | Other ₄ | Nursing | Home 5 | Residence (| 6 🗸 Other: | : Scene |
| Division of Vital Records, tal or Attending Physician: The law requir rs after death. **A Director** After this certificate has been sted in by the funeral director, page 2 should lead to be the funeral director. | Certification: To | 27. Manner of Death 1 ✓ Natural 5 Deading | 28a. Date of Injury (Month, Day,Year) | 28b. | Time of Inj | | njury at Work | | 28d. Describe I | now injury occ | urred | |
| Sior Attenc r death ector: by the | catio | 2 Accident 5 Pendir Investi | | 4 At home 6 | arm atroot | factory office | Yes 2 | | 20f Leastian /6 | Stroot and No. | mhos os Bu | ral Route Number, City |
| Division Hospital or Attence 24 hours after death Funeral Director: tely filled in by the | ertifi | 3 Suicide 6 Could 4 Homicide determ | not be | y - At Home, to | aiii, su cei | , ractory, ome | e banding, eic | · [| or Town, S | | Inder of Kur | rai Route Number, City |
| Hospi 24 hou Funer tely fil | | 29a Certifier | sician: To the best of my kr | nowledge, de | ath occurre | ed at the time, | date and pla | ice, and d | lue to the caus | e(s) and man | ner as state | ed. |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director. | Medical | one) 2 Medical Exam | and manner stated. | ation and/or i | rvestigatio | | | curred at | tha time, date | | | |
| | Σ | 29b. Signature and title of certifier | 1.1 | | | - 1 | ense number | | | l . | | nth, Day, Year) |
| 1,~ | | 30 Name and add 1 | 11 | 11. | _ | 0.0 | C.M.E. | | | July 6, 2 | U 12 | |
| ,0, | | 30. Name and address of person was Jack Titus MD. Depu | ty Chief Medical Exa | . , | 00 W. B | altimore S | treet, Balti | imore, | MD 21223 | | | |
| | | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | | | | | | | | |
| Regist | trar | 111 1 6 2012 | Пина в. | back | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael L. Mrnak Month 12 JULY 6.32AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE WASHINGTON MEDICAL ANNE unde GLEN Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 217 98 3034 Days Hours Min. Director 1 🕱 M 2 🗆 F 41 Usual Residence of Deceden 03/17/1971 Maryland permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modified Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Twin Circle Way 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Management Mr. Tire year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth Mrnak Margaret Budahazy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Mrnak / wife かとろん Twin Circle Way Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bayview Crematory 07/16/2012 Baltimore, Maryland Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Physician/ MA Onset and Death TASTATIZ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 1 ☐ Yes 2 L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be 1 ☐ Yes 2 ☐ No 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature en 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 al State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edmund Albert Minster July 10 2012 2050 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Linder 1 Year If Linder 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 207-16-5290 Director 1 X M 2 🗆 F 86 March 31, 1926 Pennsylvania show 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Silver Spring 1 Yes 2X No Montgomery Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 20901 u.s.A. 10151 Sutherland Road filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WWII White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. 12 Book Binder U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked o ၉ Ralph Albert Minster Edith Rushton traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10151 Sutherland Road, Silver Spring, MD 20901 Cheryl Minster - Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or Department of Important: If any injury or once, Lincoln Crematory 07/17/2012 Brentwood. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Systemic Inflammatory Response Syndrome disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Interstitial Obstruction Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Duodenal Mass Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bar{X} \) No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical

State Registrar

DHMH 17 Rev 06-2011

29a. Certifier

only one)

29b. Signature and title of certifier

1500 Forest Glen Road, Silver Spring, Maryland 20910 Jonathan Duran, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D66249

July 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day / Month 07 Physician/ Manya Morgulis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ukraine 1 □ M 2 🛣 F Days Hours Min. 19705/1924 Director 284-74-7419 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Rockville 1 Yes 2X No Maryland Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 6121 Montrose Road 20852 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Food Industry Chemist Technician 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hershel Morgulis Malka Roytblatt 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9313 MacSwain Place, Springfield, Virginia 22153 Department of Health Important: If item 27 any injury or other the once. Gregory Segal - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State King David Mem Grdns | 07/11/2012 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service License 1232 100000 Mellen 1800 New Hampshire Ave., Silver Spring, MD 20904 2 . Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Jementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day 1 Yes 2 No ed by the a detached i g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be def Be Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tyes Investigation after deatl Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho
To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mine 7-12-2012 DOO 64871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20852 6121 Fazli Montrose 31. Date filed (Month, Day, Year) 32. Registrar's Si State 1 6 2012 Registrar

DHMH 17 Rev 7/2009

| | | | | State of M | | | | | | | | | gible | • | |
|----------------|--|---|---------------|---|-------------------|----------------------|-------------------------|--------------------|--------------------|---------------|---------------------------------------|------------------|--------------------------|---|-----------------|
| | | | • | For State Of IVI | ai yiai iu i | | tificate | | | and ivit | entai riy | Reg. No. | 20 | 12 21 | 231 |
| | | Physicia | | 1. Decedent's Name (First, Middle, Last) Ollie Mae Parker | | | | | | | 2. Date of De | | 2°Pear | 3. Time of De 2 12:20 | |
| 8 | | Medic Examin | | 4a. Facility Name (if not institution, give street and number) | 0 | | 4b. City, | Town, or | Location | | 1017 | 4c. Cour | nty of Deat | | T IVI |
| | pref. | Farmer | | 5. Social Security Number - 16. Sex 17. Ac | e (In yrs. last L | hiethdayl | If Under | BAL | T If Under | 10RE | | N/ | | | |
| | | Funeral Director | | 214-68-3217 1 M 2 M F | 96 | Yrs. | Months | Days | Hours | Min. | 8. Date of Bir (Month, Da 05/02 | v. Year) | Co | thplace (State or Fountry) Cyland | oreign |
| | land | show | tor | Usual Residence of Decedent 10a. State 10b. County | 10c. City, To | own or Loc | | | | | | | | 10d. inside City L | imits |
| | e Mary | r 28a-f notifie | Director | MD N/A 10e. Street and Number | | | | | .more | e | | | | 1 XYes 2 | □No |
| | with th | s 23a o ust be | | 22 N. Beechfield Ave. A | Apt F | | 10f. Zip | 2122 | 9 | | | 10g. Citizen o | S.A. | - | |
| | death | r items iner m | / Fun | 11. Marital Status 12. Was Decedent Armed Forces? | | 13. W | /as Deced | ent of His | spanic Ori | gin? (Speci | fy Yes or No- can, etc.) | 1 | ace - Ame lack, White | rican Indian, | |
| 900 | NOSO rs after | ral", o Exam | ed by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. | No | 1 | ☐ Yes 2 | 2 🔀 No | Specify: | | | | ify: B] | | |
| Į. | ZIZI3-0050 within 72 hours after | ה"natu ledical | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16 | 6a. Deced (Give k | ind of worl | k done di | ition uring mos | t of working | 7 | 16b. Kind of | Business | /Industry | - |
| 5 | within | giene. er thar , the N | | Elementary/Secondary (0-12) College (1-4 or secondary) | 5+) | Mai | NOT use L d | retired) | | | | Priva | ite I | Homes | |
| 3 | be filed | ental Hy ked oth ic event | To Be | 17. Father's Name (First, Middle, Last) Clifford Harvey | | | | | | er's Name (| | Maiden Surna | me) | | |
| | Maryland 2 should be filed | Department of Health and Mental Hygiene. Important; if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 19a. Informant's Name/Relationship (Type, Print) Sheila Parker(daughter | | | | | | | | er, City or Town | | _{o Code)} 2122 | 29 |
| | Dallinore, permit. Page 1 and | of Hea If item or other | | 20a. Method of Disposition 1 Burial 2 Comments 3 Removal from State | 20b. Place | e of Dispos | sition (Nam | e of ther place | 9) | Da | te | 20c. Locatio | n - City or | Town, State | |
| 1 | ILITI nit. Pag | artment ortant: injury o | - 2 | 4 Donation 5 Other (Specify) 21. Ignatury of Funeral Service 1: epse | on-s | ite | Crea | amto | ry | 7-13 | | Balti | | | |
| 6 | Deri | Depar Impor any in | | Juguelene kar | | 21 | 40 1 | I. F | ulto | on Av | r. Fi | uneral Baltim | Hon ore, | ne PA , MD 212 | 217 |
| Į | | y ici in Medical | | 23a art 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on such line immediate Cause (Final disease or condition resulting in death) a. Due to yr as | d the death. Dee. | er | r the mode | of dying | , such as | cardiac or r | respiratory ar | rest, | | Approximate Interval Betwee Onset and Dea | ıth |
| IF. | | xaminer transit | Examiner | causé. Enter Underlying Cause (Disease or injury that initiated events c. | a consequence | 1 | Q | prie | urr | non. | Q | ¥ | | ONE MO | WTH |
| 77 5 | te be executed | ıysician and ne burial-transit | ical | resulting in death) Last | a consequenc | e of): | | | | | | | | | |
| 7 | certificate | attending physi d for use as the b | /Med | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome | of pregnancy | _ | | | | | | 0011 | | | |
| FR | To the Hospital or Attending Physician; The law requires that the death or | signed by the atten I be detached for u | Physician/Med | 235. was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 2 Fetal de | | Ectopic p Other (spe | | / | | | | Date of de | livery Day Year | r |
| \$ | uires that | been signed I should be dei | by | Part II. Other significant conditions contributing to death b | out not resultin | ig in the ur | nderlying c | ause give | en in Part | l. | 23e. Did t | | | the cause of death | |
| 7 | he law requ | te has bee | Completed | | | <u> </u> | | | | | 24a. Was auto perfo | psy prmed? | prior to death? | topsy findings avai | ilable se of |
| | cian; | nis certificate has Il director, page 2 | BeC | 25. Was case referred to medical examiner? | | _ | | - | | th (Check o | 1 Yes | a Mol | 1 LJ Yes | 3 2 No | |
| 2 | Physic | r this c eral dire | မ | 1 Yes 2 No nospital: Inpati | ent 2 ER/ | Outpatient | | Other | _4 ∐ Nı | | | dence 6 0 | | ify) | |
| 2 | tending | eath. or: After thi the funeral | Certificate: | 1 Natural 5 ☐ Pending (Month, Date 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | y, Year) | injury | М | work? | | - 1 | d. Describe i | low injury occi | iried | | |
| Living of With | tal or At | within 24 hours after death. To the Funeral Director: After completely filled in by the funer | | 4 Homicide determined 28e. Place of Injubuilding, etc | | farm, stre | et, factory, | office | | 28 | Bf. Location (S City or Tow | | iber or Rui | ral Route Number, | |
| | le Hospi | n 24 hou ie Funer oletely fii | Medical | 29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of a medical Examiner: On the basis of examiner: On the basis of examiner: To the best of a medical Examiner: To the medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the best of a medical Examiner: To the | xamination and | d/or investi | gation, in m | ny opinior | n, death oc | curred at the | e time, date a | and place, and o | due to the d | cause(s) and manne | r stated. |
| 4 | To th | withi To th | | 29b. Signature and the security A | DE | KEI | | License | | 2/0, | / | 29d. Date sign | | | |
| • | | 38h | | 30. Name and address of person who completed cause of d | eath (Item 23a | a) (Type, P | | | 110 | 1000 | | 7019 | 7) | 1017 | ~- |
| | | Stat | e | AMMER BEFELE 31. Date filed (Month, Ray) 132. Registra | ars Signature |) 9 | 005 | 3 (| Stor | Auc | 2,50 | Homi | Jor 1/ | 11) 2/ 6 | 4 |
| | | Registra | | JUL I O 2012 Clerking A | 1. Aga | Mar | | | | | | | | | |

| | | Plea | se Type or Pri | | | | | | | gible. 2012 22 |
|--|----------------------------|--|---|---|--|---|--|---|---|--|
| | | 1 = For State Registrar | Otate of Wi | ai yiai i | | ificate of | | ivientai riy | Reg. No. | 012 22 |
| Physicia Medi | | Decedent's Name (First, Middle, | , | s P. | Price | | | 2. Date of De | eath | 3. Time of Do |
| Examir | ner | 4a. Facility Name (if not institution, Baltimore Wash | | cal C | Center | - | or Location of Dea | ith | 4c. County | y of Death Arundel |
| Funeral Director | | 296 40 5466 | | e (In yrs. la 6 | ast birthday) Yrs. | If Under 1 Yea Months Days | | | ıy, Year) | 9. Birthplace (State or F Country) Marylan |
| yland f show | tor | Usual Residence of Decedent 10a. State 10b. County | | | y, Town or Loca | | | 101/01/ | 1,740 | 10d. Inside City |
| rith the Mar 23a or 28a | Funeral Director | Maryland Anne 10e. Street and Number 113 Ilene Roae | Arundel | G1 | en Bur | 10f. Zip Code 2106 | | | 10g. Citizen of U.S | · |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. | ğ | 11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent E | | | | Hispanic Origin? (ban, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Rad Bla | ce - American Indian, ck, White, etc. White |
| 215-0 lin 72 hour e. hen "natui Medical | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | t's Education | ·+) | (Give ki | ent's Usual Occu nd of work done NOT use retired | during most of w | orking | | Business/Industry |
| aryland 21215-0036 hould be filed within 72 hours after and Mental Hygiene. Is marked other then "natural", our umatic event, the Medical Exam. | To Be C | 9th 17. Father's Name (First, Middle, La | Arthur Bue | otte | | nier | | ame (First, Middle, | Maiden Surnam | |
| Maryla | | 19a. Informant's Name/Relationshi Brenda Eicher | ip (Type, Print) | | 19b. Mailing | Address (Stree | t and Number or F | ural Route Numbe | er, City or Town, S | |
| Baltimore, I bermit. Page 1 and 3 Department of Heali mportant: If item 2 my injury or other <u>pnce.</u> | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp | 3 ☐ Removal from State pecify) | C | | tion (Name of atory or other pl | ace) | Date 12/2012 | 20c. Location | -City or Town, State ore, Marylane |
| Balt permit. Depart Import any inj | | 21. Signature of Funeral Service Li | censee | In | 22. | Name and Add | ress of Facility G | once Funday Ral | eral Ser | rvice, P.A. Maryland 21 |
| Medical Examiner and he burial-transit | lical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | CQu | nence of): | small | ce 11 | ny disea | ise | Onset and Dea |
| Box 68760 e death certificate be the attending physicate for use as the base of the death of the | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 23c. If yes, outcome of the line of the l | 2 🔲 Feta | I death 3 | Ectopic pregnal Other (specify) | ncy | | | ate of delivery onth Day Yea |
| S, P.O. ires that the signed by t | b S | Part II. Other significant condition | s contributing to death bu | ut not resi | ulting in the un | derlying cause (| given in Part I. | | | ribute to the cause of deat |
| Record The law requate has beer | Completed | | | | | | | 24a. Was | an 24b. I | Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 ☑ No |
| | Ņ | 1 | | | | | Place of Death (Ch | | | 1 163 2 02 110 |
| /ital sicien: certific irector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | her: | | | |
| on of Vital nding Physicien: ath. After this certific funeral director, | To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | 1 20 Inpatie 28a. Date of injur (Month, Day | у | ER/Outpatient 28b. Time of injury | 28c. Inju | ıry at | Home 5 Residence 128d. Describe h | dence 6 Other | |
| Division of Vital Records, ital or Attending Physicien: The law requires are death. el Director: After this certificate has been sigled in by the funeral director, page 2 should b | Certificate: To Be | examiner? 1 ☐ Yes 2 No 27. Manner of Death | 1 A Inpatie 28a. Date of injur (Month, Day) | y ; Year) ry - At hor | 28b. Time of injury | 28c. Inju wo M 1 L | 4 □ Nursing iry at rk? □ Yes 2 □ No | 28d. Describe h | ow injury occurre | |
| Division of Vital the Hospital or Attending Physicien: thin 24 hours after death. the Funerel Director: After this certific mpletely filled in by the funeral director, | Medical Certificate: To Be | examiner? 27. Manner of Death 1 Natural 5 Pending 2 Accident 6 Could n 4 Homicide determin 29a. Certifier 1 Certifying N (Check 2 Medical Exonly one) Certifying N | 1 X Inpatie 28a. Date of injur (Month, Day) ation of be 28e. Place of Injur | y ; Year) ry - At hou . (Specify) my knowle | 28b. Time of injury me, farm, stree | 28c. Inju wo 1 Et, factory, office curred at the tination, in my opineath occurred at | 4 I Nursing link? Irk? Yes 2 No | 28d. Describe h 28f. Location (S City or Tow | Street and Numbern, State) | er or Rural Route Number, ner as stated. |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu | Medical Certificate: To Be | examiner? 27. Manner of Death 1 Natural 5 Pending 2 Accident Investige 3 Suicide 6 Could not determing 29a. Certifier 1 Certifying Check 2 Medical Ex | 1 X Inpatie 28a. Date of injur (Month, Day, ation of be ned 28e. Place of Injur building, etc Physician: To the best of r caminer: On the basis of ex Nurse Practitioner: To the | y ; Year) ry - At hou . (Specify) my knowle | 28b. Time of injury me, farm, stree | 28c. Inju wo M 1 E t, factory, office curred at the tin ation, in my opin leath occurred at 29c. Licen | ry at kk? Yes 2 No No, date and place ion, death occurred the time, date and se number | 28d. Describe h 28f. Location (S City or Tow and due to the call at the time, date a place, and due to the | Street and Numbern, State) ause(s) and manning place, and due the cause(s) and ni | er or Rural Route Number, ner as stated. |
| To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, | Medical Certificate: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could not determing 4 Homicide determing 29a. Certifier 1 Certifying (Check 2 Medical Exponly one) 3 Certifying 19 29b. Signature and title of certifier | 1 M Inpatie 28a. Date of injur (Month, Day, ation of be ned 28e. Place of Injur building, etc 28e. Place of Injur building, etc 28e. Place of Injur building. etc | y, Year) ry - At hor, (Specify) my knowle amination best of meath (Item | 28b. Time of injury me, farm, stree edge, death oc and/or investig y knowledge, of the control | 28c. Inju wo 1 E t, factory, office curred at the tin attion, in my opin eath occurred at 29c. Licen R10 | 4 I Nursing link? Irk? Yes 2 No | 28f. Location (S City or Tow and due to the ca at the time, date a place, and due to t | Street and Numbern, State) ause(s) and manning place, and due the cause(s) and manning place. | er or Rural Route Number, ner as stated. e to the cause(s) and mannenanner as stated. d (Month, Day, Year) |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ 0150 AM Yakov Pekarskiy 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-63-1966 Director 1 X M 2 🗆 F 80 02/10/1932 Russia Usual Residence of Decedent の名子での 28a-f shov 10a. State 10c. City, Town or Location the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Rockville Montgomery 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with U.S.A. 20850 95 Dawson Avenue, #305 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Vakov should be filed within 72 h and Mental Hygiene.
7 is marked other than "I Electronics Elementary/Secondary (0-12) Manufacturing Lead Technical Engineer injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Maria Perchik Lev Pekarskiy permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 Dawson Avenue #305, Rockville, Maryland 20850 Sofya Pekarskaya - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garden of Remembrance 07/16/2012 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ poxemic disease or condition resulting in death) Medical Due to ork s a consequence of **Examiner** 2.5 doms convent 6ta 10000000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner aortic Cause (Disease or injury 1005thetic that initiated events resulting in death) Last and e to (or as a consequence of): ding physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the formal properties of the formal prop Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of persound completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Divi, ROUNNIE, Bridgit Alum Kara, MD 32 Registrar's Signature Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5 Month 7 2012 14:50 P Mohammed H. Rassul Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) Hours Min Days Director 90 216-13-9762 1/15/1920 Afghanistan Usual Residence of Decedent or 28a-f show with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 20852 U.S.A. 1045 Copperstone Ct. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: White "natural", 3 X Widowed 4 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the Afganistan Army Military General Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mohammed Rassul Roshan Rassul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2186 Wolftrap Court, Vienna, Virginia 22182 Homa Rassul - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State National Memorial Park 7/6/2012 Falls Church, VA injury 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee Kurt Blake 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ventricular Tachycardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Atrial Fibrillation Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): attending physician 14'50 pm 7/5/12 Physician/Medical End Stage Renal Disease s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Division of Vital Records, Anemia 24a. Was an Were autopsy findings available prior to completion of cause of the Hospital or Attending Physician: The law autopsy performe**x** death? Rassul, Mohammed Respiratory Acidosis certificate Yes 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) P 2 🗓 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No 2 Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 7/5/2012 29b. Signature and title of certifi D0068160

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who

Kimberly Zuzak
31. Date filed (Month. Dav. Year)

8600 Old Georgetown Rd. Bethesda, MD 20814

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 22352

Certificate of Death

Reg. No.

| | | | 1 - State Registrar | Cer | tificate of L | Death | ĺ | Reg. No. | | |
|---------------------|--|------------------|--|-------------------------------|---|------------------|---|-------------|----------------------|--|
| | Dhysisis | -/ | 1. Decedent's Name (First, Middle, Last) | | · | | 2. Date of De | ath | V | 3. Time of Death |
| ш | Physicia Medic | | Vimala Shanmugam | | | | July | 12, | 2012 | 9:48 P M |
| | Examin | er | 4a. Facility Name (if not institution, give street and number) | | 4b. City, Town, or | r Location | of Death | 4c. | County of Death | |
| Annual Contract | | | 7581 Easton Club Drive | | | asto | | | Talbot | |
| B. | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. Iz 095–56–7456 1 □ M 2 ⋈ F | | If Under 1 Year Months Days | If Unde Hours | r 24 Hrs. 8. Date of Bir Min. (Month, Da | | 9. Birthp Count | lace (State or Foreign ry) |
| Ε. | | | U95-56-7456 1 □ M 2 ☑ F Usual Residence of Decedent | 59 Yrs. | | | August | 9, 19 | 52 I1 | ndia |
| | and show | 5 | | y, Town or Loc | cation | | | | 10 | Dd. Inside City Limits |
| | faryla 8a-f tified | Director | Maryland Talbot | | Easton | | | | | 1 ¥ Yes 2 ☐ No |
| | or 2 | | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citi: | zen of What Count | try? |
| | with 3 23a ust b | Funeral | 7581 Easton Club Drive | | 216 | 01 | | | United S | States |
| | leath items er m | Ε̈́ | 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? | | Was Decedent of H | ispanic Or | igin? (Specify Yes or No- n, Puerto Rican, etc.) | 1 | 14. Race - America | an Indian, |
| 36 | ifter of ", or amin | by | 1 Never Married 2 Married 1 Yes 2 X No | | Yes 2 X No | | · | | Black, White, e | an Indian |
| 8 | urs a tural | ted | 3 🗆 Wildowed 4 🗀 Divorced Year or Dates. | | l les 2LXINO | Specify | | s | Specify: AS 18 | an matan |
| Maryland 21215-0036 | 72 ho "na" edic | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give k | lent's Usual Occup kind of work done o | | st of working | 16b. Kir | nd of Business/Ind | lustry |
| 12 | ithin ene. thar he M | lo S | Elementary/Secondary (0-12) College (1-4 or 5+) | life. DC | O NOT use retired) Homemal | zor | | | Own Hor | ma. |
| d 2 | ed w Hygi other | Be | 17. Father's Name (First, Middle, Last) | | Homemai | | ner's Name (First, Middle, | Maidan S | | inc . |
| lan | be fill ental ked c ev | မ | Annamalai Ramanathan | | | | gammai Rama | | umame | |
| ary | nd Mi mar | | 19a. Informant's Name/Relationship (Type, Print) | 19h Mailin | na Addrass (Straat : | | er or Rural Route Numbe | | Town State Zin C | ode) |
| Ž | d 2 shalth a alth a 27 is | | Kasinathan Shanmugam/Husband | 1 | | | rive, Easto | | , | · · |
| re, | 1 and item othe | | 20a. Method of Disposition 20b. Pl | lace of Dispos | sition (Name of | - | <u> </u> | | cation - City or Tov | |
| mo | Page nent c int: If | | 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | West A | natory or other place Arunde I | ie) | July 15, 2012 | റർമാ | nton, Mai | rv1 and |
| Baltimore, | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | - 6 | 21. Signature of Funeral ervice Licensee | | atory . Name and Addres | ss of Facili | eral Home & | | | |
| m | a P P P | | MARIEC X MED MO1386 | | onaldson 411 Anna | rune oolis | ral Home & Road, Oden | ton. | atory, P Marvland | .A. d 21113 |
| | h sician Medical Examiner | er | 23a. Part 1. Enter the disease, or of implications that caused the death shock, or head for the List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence) | CQ1 | ncer ncer | g, such as | cardiac or respiratory an | est, | | Approximate Interval Between Onset and Death |
| 8760 | death certificate be executed ne attending physician and ed for use as the burial-transit | Medical Examiner | cause. Enter Underlying Cause (Disease of injury) that initiated events resulting in death) Last C. Due to (or as a consequence) d. | , | | | | | | |
| | | Physician/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | I death 3 | Ectopic pregnanc Other (specify) | у | | 2 | 3d. Date of deliver | ry Day Year |
| Js, P.O. | requires that been signed I should be def | by | Part II. Other significant conditions contributing to death but not resu | ılting in the ur | nderlying cause giv | ren in Part | 1. 23e. Did to | · · | e contribute to the | e cause of death? |
| Vital Records, | The law ate has page 2 | Completed | | | | | | | | sy findings available apletion of cause of |
| ta | sician: The certificate irector, paq | Be | 25. Was case referred to medical examiner? Hospital: | | 26. Pla | | th (Check only one) | | | |
| | Phys this ral dii | . To | 1 Inpatient 2 I | ER/Outpatient 28b. Time of | t 3 🗆 DOA | 4 ∐ N | ursing Home 5 Resid | | | |
| 0 _ | ding h. After fune | ate | 1 Natural 5 Pending (Month, Day, Year) | injury | 28c. Injury work' M 1 🗆 | | 28d. Describe h | ow injury | occurred | |
| Division of | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Il Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify) | | | ies 2L | | | Number or Rural F | Route Number, |
| | the Hospi hin 24 hou the Funer upletely fill | Medical | 29a. Certifier (Check 2 Medical Examiner: On the best of my knowle only one) 3 Certifying Nurse Practitioner: To the best of my knowle | and/or investi | igation, in my opinio | n, death o | ccurred at the time, date a | nd place, a | and due to the caus | se(s) and manner stated. |
| _ | To To Con To To To To To To To To To To To To To | | 29b. Signature and title of contifier | | 29c. License | number | | 29d. Date | signed (Month, Da | ay, Year) |
| | 1000 | | 1 M. Men h | ND | 1)00 | 160 | 404 | 7 | 113/1 | 2 |
| | 1 (2) | | 30. Name and address of person who completed cause of death (Item) | 23a) (Type, Pr | rint) Drug | 2 5 | uile 301 | FO | Ston. 1. | 10 2/601 |
| | | | Q. William Gai, MD - 826 31. Date filed (Month, Day, Year) 32. Registrar's Signatu | | אוועושוא | 0,0 | ww 301 | <u> </u> | | |
| | Stat | е | 31. Date filed (Month, Day, Year) 32. Registrar's Signatu | 1 ha | Mal | | | | | |

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AMEND ITEM# 2perPHYS, G929, 7/19/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Murielle B. Simenauer 2012 $11:00\alpha^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens - Riderwood Silver Spring 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🗶 F Months Hours 578-40-8968 Min. (Month, Day, Year) 10/05/1923 **Director** Australia Usual Residence of Decedent show ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Prince George's 1 ☐ Yes 2 No Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road, EV2102 20904 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aid Public Schools permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorrie Sakk Abraham Barrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Simenauer - Son 1479 Kingstream Drive, Herndon, Virginia 20170 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery: 07/13/2012 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Katni 11800 New Hampshire Ave.,Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Chronic Obstructive Pulmonary Disease disease or condition Years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a someguence oi). if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery Live Birth 2 Lipetar Seath
Pregnant at time of death
Unknown in the past 12 months?
1 ☐ Yes 2 XNo
9 ☐ Unknown ò Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hupertension Completed 1 🗆 Yes 2 💢 No 3 🗀 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 Homicide e Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 15860Ce

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of pe

Eileen Gemmell, 31. Date filed (Month, Day, Year) 3160 Gracefield Road, Silver Spring, Maryland 20904

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #1.30, per phy. g929 7-16-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 Day Roland. Thomas, SR.)Month Year 12:47 PM **Physician** 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-36-6995 Days MD **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Baltimore 1 Yes 2 ☐ No MD **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Frankford Are -USA 21206 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custodiar 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Robinson Thomas Kichard ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3011 Chesterfield Are. Bererly Thomas Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial f Date 20a. Method of Disposition Bultimore, Md Department of H
Important: If ite
any Injury or otl Burial 2 Cremation 3 ☐ Removal from State 14/12 4 ☐ Donation 5 ☐ Other (Specify) Laughn Greene Fineral sers 21. Signatur Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final onastanduna ASCVD **Physician** disease or condition resulting in death) , /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Orleans or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Dav filled in by the funeral director, page 2 should be detached for 5 Other (specify) Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🔲 No 1 TYes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 es 2 □ No 2 SER/Outpatient 3 DOA 6 ☐ Other (Specify) 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Alatural 2 Accident 5 Pending investigation Injury 1 Tes 2 🗌 No Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide twicertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 MO. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Sharon Pamela Bord 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1:20 Physician/ 2019 Medical City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number) **Examiner** Baltimore moria Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Country) **Director** 1 🗆 M 2 🔀 F 12-13-193. 10d. Inside City Limits 28a-f shov County 10c. City, Town or Location notified at Completed by Funeral Director Battimore 1 Yes 2 No 10g. Citizen of What Country? Street and Number ò must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, ၉ 19b. Mailing Address (Street and Number 20c. Location - City or 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 0 1202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** RENAL DISEASE STAGE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed SECOND DEGREE HEART that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy fo in the past 12 months? Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No g Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I committeely filled in by the funeral director, pag 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 1XNatural 5 Pending 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29c. License number : MD V ress of person who completed cause of death (Item 23a) (Type, Print) 201 E. UNIVERSITY PKWY, 21218 UNION MEMORIAL HOSPITAL 31. Date filed (Month) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TALBOTT ROBERT 12:31AM JULY 2012 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL MEDSTAR HARBOR BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number Sex XX M 2 □ F 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 65 Months Days Hours 018-36-8344 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f MD Baltimore 1 XYes 2 □ No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code ould be filed within 72 hours after death with nd Mental Hygiene. marked other than "natural", or items 23a Funeral 2622 Rittenhouse Ave. 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, Do NOT use retired) Stock Clerk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 Is marked ott 18. Mother's Name (First, Middle, Maiden Surname) ည unk unk 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2622 Rittenhouse Ave., Baltimore, MD 21230 Mary Talbott / Wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of W. Arunde I Crematory 07/14/2012 Odenton, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Railey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 Male 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Pnysician/ disease or condition DAY Medical resulting in death) Due to (or as a consequence of): Examiner NEUTROPENIA IDAY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a conseduence of burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the ! attending phase as the IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown P.0. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, LUNG CANCER 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law Jas autopsy performe certificate 1 🗌 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES MD JULY Atto 13 2012

DHMH 17 Rev 7/2009

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State

Registrar

3001 SOUTH HANOVER STREET, BALTIMORE, MD -21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VASAVADA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ E, Thompkins 2:20 pM Sobert Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical center 4b. City, Town, or Location of Death **Examiner** Baltimore 7. Age (In yrs. last birthday) If Under 8. Date of Birth Security Number **Funeral** 216-42-2929 (Month, Day, Year) Hours 68 Director 12,30,1943 Maryland 28a-f shov 10c. City, Town or Location marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Pasadena Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21122 8015 Corkberry Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Page 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Adm Claims Adjuster 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Agnes May Dixon Paul A. Thompkins, Sr. other traumatic and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 8015 Corkberry Ln 27 Diana Thompkins - Wife Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 D Burial 2 Crematern 1 Pre-monagen State Glen Haven Mem Pk 7/14/12 Glen Burnie, MD 4 Donation 5 X Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Funeral Service Licensee Home, PA D 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final week Physician) Ticemia disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying оны то Колявля есопьющими об обattending physician and after use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy Yes 2 1 ☐ Yes 2 ☐ No after death.

Director: After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Medical Certificate: To Be examiner? 2 No ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a

To the Funeral D

completely filled 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number NP1:1548536543 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Kyan Moran 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 1 6 2012 Registrar

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| ı | Physicia Medic | | Clarence t | E. Woods | Sr. | | | Month JULY | Day | Year | 3. Time of Death 16 27 M |
| | Examir | | 4a. Facility Name (if not institution, giv | e street and number) | | 4b. City, Town, or | Location of Death | | 4c. County | | |
| | Francis | | ST AGNES 5. Social Security Number 6. | HOSPITA | | BAL If Under 1 Year | TIMOR If Under 24 Hrs. | | | NA | |
| Ш | Funeral Director | | dia and an and | 1 XM 2 □ F | 7 Yrs. | Months Days | Hours Min. | 8. Date of Birtl (Month, Day | | Countr | |
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| | arylan a-f sh fied a | Director | MAN Ballo | C. 10c. | City, Town or Lo | cation | | | | 10 | d. Inside City Limits 1 Yes 2 No |
| | or 28 | ğ | 10e. Street and Number | ω. | | 10f. Zip Code | | | 10g. Citizen of \ | What Countr | |
| | 72 hours after death with the Maryland n"natural", or items 23a or 28a-f show fedical Examiner must be notified at | Funeral | 912 S. Rollin | a Rd. | | 212 | 178 | | US | | , |
| I. | r deat r iten iner r | | 11. Marital Status 1 ☐ Never Married 2 ※ Married | 12. Was Decedent Ever in Armed Forces? | | Was Decedent of His f Yes, specify Cubar | spanic Origin? (Spe n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | e - America k, White, et | |
| 036 | safte ral", o Exam | ed by | 3 Widowed 4 Divorced | Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. | | I ☐ Yes 2 No | Specify: | | Specify: | 0 | 4 |
| 21215-0036 | s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical | Completed | 15. Decedent's l (Specify only highest g | Education | 16a. Deced | dent's Usual Occupa kind of work done d | ation | ina | 16b. Kind of B | | |
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| ylan | | 오 | Burl Woods | | | | | a B. | _ | •/ | |
| Maryland | and and is m | | 19a. Informant's Name/Relationship (| Type, Print) | 19b, Mailir | ng Address (Street a | nd Number or Rura | l Route Number, | City or Town, S | | de) |
| | 1 and 2 s f Health item 27 other tra | | Laura L. Wood 20a. Method of Disposition | 15- Daughter | Place of Dispo | | ck Ct. | Colum | bia, M | 02 | 1046 |
| Baltimore, | | | 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State | cemetery, cren | National | e) :/- | Date Date | Calver | | 1 |
| alti | permit. Page Department of Important: If any injury or once, | | 21. Signature of Funeral Service Licen | | | . Name and Address | s of Facility | arch P | H- Ba | c+ | 1 7 |
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| | Physician Medical | | disease or condition resulting in death) | a. Due to (or as a conse | | S LEAT | DING TO | o sef | TIC SH | OCH I | Dinset and Death リNKNののへ |
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| | be executed sician and burial-transi | xan | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a conse | quence of: | | | | | | |
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| 876 | ificate ng phy as the | Med | IF FEMALE: | - u | | | | | | | |
| 9 × | th cert ttendir or use | ian/I | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregr | etal death 3 | | / | | | e of delivery | |
| Bo | r the a | Physician/Med | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4 ☐ Pregnant at time o 9 ☐ Unknown | f death 5 ∟ | Other (specify) | | | Mor | nth D | ay Year |
| P.0 | requires that the death certificate been signed by the attending phy should be detached for use as the | | Part II. Other significant conditions of | | | | | | pacco use contr | bute to the | cause of death? |
| ds, | quires en sigi ould b | Completed by | COPD, A | bolominal | Aor | tic Ane | urysm | 1 □ Ye | es 2 🗆 No | 3 🗌 Probal | bly 4 Unknown |
| cor | law re las be | nple | | WE HEAR | T FAI | LURE, | • | 24a. Was ar | | Vere autopsy | y findings available bletion of cause of |
| Re | rsician: The law r s certificate has b director, page 2 s | | | ENSION | | | | _ perforr | ned? L d | eath? | No |
| /ita | /siciar | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 Inpatient 2 | TER/Outration | Other | ce of Death (Check | | | | |
| of | ng Phy ter this neral o | | 27. Manner of Death | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury | 28c. Injury work? | 4 Nursing Hor | me 5 🗀 Reside 28d. Describe ho | | | |
| ion | tendiir Jeath. Ior: Af the fu | Certificate: | 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b | 1 | I mary | M 1 🗆 Y | ′es 2 □ No | | | | |
| Division of Vital Records, P.O. Box 68760 | I or At after of Direct d in by | Cert | 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Speci | nome, farm, stre ify) | et, factory, office | 2 | 28f. Location (Str City or Town | | r or Rural Ro | oute Number, |
| | To the Hospital or Attending Physician: The law requires that the death certificate within 24 herours after death. When the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the | Medical | 29a. Certifier 1 Certifying Phy | sician: To the best of my know | wledge, death o | ccurred at the time, | date and place, an | d due to the cau | se(s) and manne | er as stated. | |
| , | the H thin 24 the Fu mplete | | only one) 3 Certifying Nur | iner: On the basis of examinati se Practitioner: To the best of | on and/or investi | gation in my opinion | death occurred at : | the time date and | dinace and due | to the cause | (c) and manner etated |
| | 5 5 × 5 | | 29b. Signature and title of certifier M. Sünd | luya MD | | 29c. License | | | 9d. Date signed | | v, Year) |
| | 151 | ŀ | 30. Name and address of person who | completed cause of death (Ite | m 23a) (Type, Pr | rint) | 24433 | | 7/11/ | • | |
| | 1 | | SINDHUJA MA | RUPUDE 90 | O CAT | DN AVE | ENUE, B | BALTIM | IORE, 1 | 4D : | 21229. |
| | Stat Registra | е | 31. Date filed (Month Day Year) JUL 1 6 2012 | 32. Registrar's Sign | ature Earl | | | | - | | |
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| - | Physicia Medi | | Catherine | | Adams | | | June Month | | 9ear 012 | 11:40a ^M |
| | Examir | ner | 4a. Facility Name (if not institution, give street 23845 Mervell De | · · | | 4b. City, Town, or Ho1 | Location of Dea | th | 4c. County | of Death Mar | y's |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | | th | 9. Birthp Count | place (State or Foreign |
| | Director | | 579–20–2958 1 ☐ Usual Residence of Decedent | M 2 🛣 F 90 | Yrs. | , | | 06/22 | | | Saryland |
| | yland f shov ed at | ţċ | 10a. State 10b. County | | y, Town or Loc | | | | | 11 | 0d. Inside City Limits |
| | ne Mar ne 28a | Direc | Maryland St. Ma | ry's | Ho11 | ywood 10f. Zip Code | | | 10g. Citizen of V | What Cour | 1 Yes 2 X No |
| | with the s 23a c | Funeral Director | 23845 Mervell Dea | an Road | | 2063 | 36 | | U S | | .,, |
| 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Fur | 11. Marital Status 1 Never Married 2 Married 3 Status 1 Divorced | 2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates. | If | /as Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No | n, Mexican, Pue | | | e - America k, White, e Wh | etc. |
| 15-0 | 72 hou "natu edical | plet | 15. Decedent's Educ (Specify only highest grade | | (Give k | ent's Usual Occupa | | orking | 16b. Kind of Bu | usiness/Inc | lustry |
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| | ntal Hyg ed oth | To Be | 17. Father's Name (First, Middle, Last) Joseph Benjami | n Morgan | | | 18. Mother's N | ame (First, Middle, Pills | Maiden Surname | e) | |
| Maryland | hould band Me s mark | | 19a. Informant's Name/Relationship (Type | _ | 19b. Mailin | g Address (Street a | | | | tate, Zip C | |
| | and 2 s Health a m 27 i | | Patricia Burney/Da | | | 3 Joy Cha | pe1 Roa | | | | |
| Baltimore, | age 1 a ent of H nt: If ite y or ot | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | emoval from State | lace of Disposemetery, crem St. Jol | atory or other plac | | Date 26/2012 | 20c. Location - | - | |
| altir | permit. P Departme Importar any injur | | 21. Signature a Farman Specify | 1 | | | | | | _ | |
| <u> </u> | e a II e e | - 1 | 1504/07 | David Gof: | | Name and Address lattingle | | | | MD 2 | |
| = | Medical Examiner | | 23a. Part . Enter the disease, or comflict shock, or heart failure List only one Immediate Cause (Final disease or condition resulting in death) | ations that caused the death cause ornch line. Due to (or as a consequ | itia | The mode of dying | g, such as cardia | c or respiratory ar | 1651, | | Approximate Interval Between Onset and Death |
| | cate be executed physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last | Due to (or as a consequ | | | | | | | |
| 092 | te be (hysicia the bur | edical | d. | | | | | | | | |
| Box 68 | Hospital or Attending Physician: The law requires that the death certifice 24 hours after death. Funeral Director: After this certificate has been signed by the attending pately filled in by the funeral director, page 2 should be detached for use as: | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowh | c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d g Unknown | l death 3 🗌 | Ectopic pregnanc Other (specify) | У | | 23d. Da Mo | te of delive | ery Day Year |
| P.O. | s that the | | Part II. Other significant conditions cont | | | nderlying cause giv | en in Part I. | | | | e cause of death? |
| rds, | equire seen si hould | eted | hypertent Setzure | 1000 | | <u>.</u> | | [90] | | | pably 4 Unknown |
| of Vital Records, | The law i ate has t page 2 s | Completed by | serwre. | arsoraer | | | | 24a. Was auto perfo | psy ormed2 | orior to cor death? | osy findings available mpletion of cause of |
| al B | sician: The certificate I irector, pag | Be C | 25. Was case referred to medical examiner? | | | 26. Pla | ace of Death (Ch | | 2 A No | 1 🗌 Yes | 2 L No |
| f Vii | Physicia this cert ral direct | 은 | 1 ☐ Yes 2 🔼 No Ho 27. Manner of Death | spital: 1 ☐ Inpatient 2 ☐ I 28a. Date of injury | ER/Outpatient 28b. Time of | | 4 □ Nursing | 1 | dence 6 🗆 Othe | | |
| o uc | ath. r; After re funer | icate | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | injury | 28c. lnjury work' M 1 🗆 | Yes 2 No | 28d. Describe i | now injury occurre | ea | |
| Division | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur | al Certificate: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify) |) | | | City or Tov | | | |
| | n 24 hor n 24 hor e Fune sletely fi | Medical | (Check 2 Medical Examine | an: To the best of my knowler: On the basis of examination Practitioner: To the best of m | and/or investi- | gation, in my opinio | n, death occurred | d at the time, date a | and place, and due | e to the cau | ise(s) and manner stated |
| | To the within 2 To the comple | - | 29b. Signature and title of certifier | | 5, | 29c. License | number | . | 29d. Date signed | d (Month, E | Day, Year) |
| | | | 30. Name and address of person who com | unleted cause of death //t | 22a) /Time D | | 1551 | 01 | 06-2 | 3 - | 2012 |
| 3 | | | Jennifer Schmidt | | | hants Lai | ne, Leon | ardtown | MD 206 | 50 | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Signat | ure | 41 | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DYear 9:15 PM Maclean June George Arthur Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner aurel Regional Hospita Prince George Laure 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** . Age (In yrs. last birthday) Months Hours Min. Month, Day, Year) _/19/1960 1 X M 2 □ F Director 219-81-3953 Accra Ghana Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified ** 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 ☐ No Beltsville Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 USA 11352 Cherry Hill Rd #101 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Black, White, etc Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: African 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Porter Private unkBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lilv Vanderpuije Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5960 Watch chain way #1205 Columbia, MD 21044 Solomon S. Adjetey/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐yBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 7/7/12 Silver Spring, MD 21. Signature of Pheral Service 1 censee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) hour Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal dea
Pregnant at time of death in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 ∐ 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D54223 Laurel Regional Hospital Dept, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U

DHMH 17 Rev 7/2009

State Registrar en

R'd.

7300 Van Dusen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Samuel E. Allen June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Doctor's Hospital Lanham Prince George's Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 577-38-9577 Director 1 X M 2 □ F 83 5(1/31/1/19/2/9^{ar)} North Carolina Yrs Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3913 Sunflower Circle 20721 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: "natural", 3 X Widowed 4 Divorced Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs Visual Information Specialist Government Be 17. Father's Name (First, Middle, Last) e 1 and 2 should be filed of Health and Mental H fitem 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) un Halice Allen 19a. Informant's Name/Relationship (Type, Print)
Leon 0. Allen/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3913 Sunflower Circle Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 = 6 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 6/25/12 Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Servi Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician. THYMIO disease or condition Medical resulting in death) Due to (or as a consi quence of): Examiner rostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 No g Unknown 9 Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by preumonia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate 2 🗆 No Yes 2 No 1 Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 📈 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft
id in by the fu Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours

To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ashi 02822 Name and address of person who completed cause of death (Item

JR. Catvam Vashi du Vashi Satyam

State

Registrar

JUN 2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 20 | 12 | 22 | 36 | 1 |
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|----|----|----|----|---|

| yao | | 1- For State Certificate of Death Registrar | | . No. | |
|---|------------|--|---------------------------------|--|------------------------------|
| Physicia | an/ | 1. Decedent's Name (First, Middle,Last) | 2. Date of Death Month | Day Year | 3. Time of Death 0720 hrs |
| Medical Exami | ner | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca | July 2, 2012 | 4c. County of Death | |
| | | Shady Grove Adventist Hospital Rockville | | Montgomery | |
| Funeral | | | | (MM/DD/YYYY) 9. Bir Foreig | |
| Director | | 670-03-5484 1 MM 2 F 4Z Yrs. Months Days F | lours Min. 06-25 | - 1970 00 | untry) Somalia |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| ≜ .π | | . 1111 * | | | 1 Yes 2 No |
| Maryland 28a-f show d at once. | Director | VA Prince William Manassas 100. Street and Number 101. Zip Code | 10g | . Citizen of What Cou | ntry? |
| th the Maryland 23a or 28a-f sho notified at once | Dire | 12501 Brenmill Lane 20112 | | Somali | a |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once | era | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic | | | can Indian, Black, |
| or deat | Fun | 1 Yes 2 P No | | 0.1 | 1. |
| irs afte | p | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (| Give kind of work done | Specify: B16b. Kind of Business/ | ack Industry |
| 72 hor | etec | Elementary/Secondary (0-12) College (1-4 or 5+) | NOT use retired) | • | . 1 |
| 2036 vithin ene. | Completed | 12 Attendent | | | Service |
| nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene. f: If item 27 is marked other than other traumatic event, the Medical | ပိ | | other's Name (First, Middle, Ma | 4 | |
| 212 Auld be Mentz mark | 0 8 | Abdirahman Ahmed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and | Number or Rural Route Numb | amed er, City or Town, State | , Zip Code) |
| ore, MD es I and 2 sho of Health and If item 27 is | | Abdirashid Ahmed Cousin 6033 Callaw | | treville, | |
| ore, MEss 1 and 2 soft Health at If item 27 | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place) 20b. Place of Disposition (Name of cemeter crematory or other place) | | 20c. Location - City or | |
| Baltimore, permit. Pages 1 an Department of Hee Important: If ite | | A Descripe & Other Specific | | Stafford | |
| Baltimo permit. Page Department or Important: injury or otd | | 21. Signature of Funeral Service Licensee Ho #1070 22. Name and Address 1242 Easy | al Till | slym Fun | era Service |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such | as cardiac or respiratory arres | t, shock, or heart | Approximate Interval |
| /Medical | | failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular | Nicesce | | Between Onset and Death |
| Examiner | | or condition resulting in death) Due to (or as a consequence of): | 22.12.12.12 | | |
| | 2 | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | |
| | 틸 | cause. Enter Underlying Cause (Disease or injury that initiated events resultion in death). Last Due to (or as a consequence of): | - | | |
| uted Id ransit | Ä | events resulting in death) Last Due to (or as a consequence or): d. | | | |
| 760, cate be executed physician and the burial - transit | Medica | ■ AMENDED 23a,27,per me,g929 7-17-1 | 2 sm | | |
| 760, icate be g physic the bur | | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ec | tonio prognanciu | 23d. Date of delivery | |
| Box 687 e death certifice the attending p | cian | past 12 months? 4 Pregnant at time of death 5 Other (Specify) | topic pregnancy | IVIOTIUT L | Day Year |
| Box 687 ne death certific the attending pred for use as the | Physician/ | 1 Yes 2 No 9 Unknown 9 Unknown | D. J. D. Did tak | acco use contribute to | the serve of double? |
| , P.O. | b F | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given | | 2 No 3 ✓ Prob | |
| ords, w requires is been signaled be | ted | | 24a. Was an | | topsy findings available |
| cor e law r e has b | Completed | | autopsy perform 1 ✓ Yes 2 | ed? death? | completion of cause of |
| Vital Rec ysician: The his certificate director, page | | 25. Was case referred to medical 26.Place of Do | eath (Check only one) | NO TO TO | es 2 No |
| Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been set in by the funeral director, page 2 should be | o Be | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other | 4 Nursing Home 5 R | esidence 6 Other | : |
| ding Ph | Ľ: | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at V | | w injury occurred | |
| Sior Attend r death ector: by the | cation: | 2 Accident Investigation 28e Place of Injury. At home farm street, factory office huilding | | reet and Number or Ru | ral Route Number, City |
| Divi | Certific | 3 Suicide 6 Could not be determined (Specify) | or Town, Sta | | , , , |
| | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an | | | |
| To the How within 24 h To the Fut completely | Medical | one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated. | | | |
| | Σ | 29b. Signature and title of certifier 29c. License nun O.C.M.E. | | 29d. Date signed <i>(Moi</i> July 3, 2012 | nin, Day, Year) |
| / | | 30. Name and address of person who completed cause of death (Hem 23a) | | - II, 0, 2012 | |
| S | | Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Ba | altimore, MD 21223 | | |
| | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | |
| Regist | rar | JUL 06 2012 Dema D. Jakes | | | |

OCME

12-04982

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 22363 State of Maryland / Department of Health and Mental Hygiene Ralph D. Bingnear 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 3, 2012 1046 hrs **Medical Examiner** Ralph D. Bingnear 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Kent Chester River Hospital Center Chestertown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY Birthplace (State or **Funeral** Foreign Pennsylvania
Country) Months Days Hours Director 04/15/1956 175-46-7074 56 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 X No Oxford Chester Pennsylvania permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other thao "oatural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19363 United States 192 Glen Hope Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No 4 Divorced 1 Yes 2 X No specify: 3 Widowed If Yes, Give Yeer Specify: White \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Pipefitter Oil Refinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tant: If item 27 is marked or other tranmatic event. George Bingnear, Sr. Ruth Warrington å 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa C. Bingnear/Wife 192 Glen Hope Road, Oxford, PA 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State Baltimore, Ju1v crematory or other place) Burial 2 X Cremation 3 Removal from State 2012 Garnet Valley, PA Pagano Crematory 4 Donation 5 Other Specify ature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Atteodiog Physiciao: The law requires that the death certificate be executed edical attending physician or use as the burial -UNPENDED **AMENDED** Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknowr Unknown 23e. Did tobacco use contribute to the cause of death? <u>P</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed by 2 should be detach 2 1 Yes 2 No 3 Probably 4 V Unknown pleted Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed Com Yes 2 No 1 Yes 2 No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 2 No 1 Yes 28c. Injury at Work? 28d, Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 1 V Natural 1 Yes 2 No Division Pending death. Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide hours after Could not be or Town, State) determined Homicide To the Fuoeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24] Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 4, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year) Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician/ 1:30 Αм Jav Robert Burns Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Queen Anne's Chester 1619 Chester Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days 80 yrs. Director 483-28-7742 1 🛛 M 2 🗌 F 6/21/1932 Lowa Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c, City, Town or Location ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, <u>the Medical Examiner must be notifled at</u> 10a. State Director 1 Yes 2 X No MD Queen Anne's Chester 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21619 1619 Chester Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Armed Forces?

No If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate ΊΔ Real Estate Agent Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Mansel W. Burns Nellie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Basil-Burns / 1619 Chester Rd., Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 6/25/2012 Edgewater, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the discuss, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cer who Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Tinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de Completed by 1 Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 00 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year) 06/25 10×1 on who completed cause of death (Item 23a) (Type, Print) 210 ANNOPORIS MO2140

Registrar

State

| Amend #7 per FI | | | Type or P | | | | | | | | _ | ole. | |
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| AACO health Dep | α. 1 - | 6-2/-12 Kan For State Registrar | State of I | Marylan | • | artment of tificate of | | and N | /lental Hy | • | 0.0 | 10 | 2226 |
| | | Decedent's Name (First, Middle, La | , | | Cer | uncate or | Deain | | 2. Date of De | Reg. N eath | | 16 | 3. Time of Death |
| Physician/ Medical | | Dorothy Pearl | | | | | | | June | 25 | ay 20 | ^{'ear} 12_ | 1:45 P M |
| Examiner | | Facility Name (if not institution, giv Ginger Cove Hea | lth Cente | r | | 4b. City, Town, | Annap | ∞lis | | | c. County of Anne | | ndel |
| Funeral Director | 5: | 59–30–2011 sual Residence of Decedent | Sex 7 I□M2 X F | Age (In yrs. Ia 98 | 97 _{Yrs.} | If Under 1 Yea Months Day | | Min. | 8. Date of Bi (Month, Di Aug. 1 | ay, Year) | | Coun | place (State or Foreign try) York |
| aryland a-f show lled at | | i. State 10b. County aryland Anne Ar | undel | 10c. City | y, Town or Loc | | napol | is | | - | | 1 | 0d. Inside City Limits 1 ☐ Yes 2√1 No |
| leath with the Maryland Itams 23a or 28a-f sho ar must be notified at Funeral Director | 10e | L Street and Number 224 River Cresce | ent Drive | | | 10f. Zip Code | 214 | 01 | | 10g. C | itizen of Wh | | |
| | ٠ | Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates | s? C KNo | | Vas Decedent of Yes, specify Cu | | | ecify Yes or No Rican, etc.) | - | 14. Race - Black, Specify: | Americ White, Whi | etc. |
| 21215-003 within 72 hours e lene. r then "natural" the Medical Ex | F | 15. Decedent's (Specify only highest gible) Elementary/Secondary (0-12) | | or 5+) | (Give I | lent's Usual Occ ind of work don O NOT use retire | during mo | st of work | ing | 1 | Kind of Busi | | dustry |
| d 21 led with Hygier other t ent, tr | 17 | 12 Father's Name (First, Middle, Last) | | | | Homema | 1 | novie Nam | e (First, Middle | | wn Ho | ne | |
| yland be flik Indental narked or netic eve | I | Hans Andersen | | | т | | Мо | lly (| hriste | nsen | l . | | |
| Baltimore, Maryland 21215-0036 semit. Pege 1 and 2 should be filed within 72 hours efter beperment of Health and Mental Hyglene. mportant: If item 27 is marked other then "natural", o my injury or other traumetic event, the Medical Even nace. To Be Completed by | I | a. Informant's Name/Relationship (Elinor Miller/da | | Lasi a | 3775 I | Esther W | ay, P | .O. E | 30x 64, | Tet | on Vi | llag | |
| limor Pege 1 cament of P tant: If ite | 20a | . Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | Removal from Sta | ate Co | emetery, cren | sition (Name of natory or other parties of crema | | | Date 3/2012 | | Location - C | - | wn, State Iaryland |
| Ball permit Depart Import any In | 21. | Signature of Funeral Service Licer | - Vlobe | it | 14 | . Name and Add | ress of Facil | ^{ity} Joh ouces | n M. Ta | aylo | r Fund | eral lis, | . Home MD_21401 |
| Physician/ | Imi | A. Part 1. Enter the disease, or con shock, or heart failure. List only mediate Cause (Final lease or condition | nplications that causone cause on each | sed the death line. | | | | | | | | 14 | Approximate Interval Between Onset and Death |
| Medical Examiner | | sulting in death) | Due to (or a | as a consequ | nce of) | | | | | | | 1 | |
| e executed lan end urial-transit | if a | quentially list conditions, iny, leading to immediate use. Enter Underlying use (Uisease or injury at initiated events | Due to (or a | as a consequ | ence of): | | | | | | | | |
| e <u>F</u> | res | sulting in death) Last | Due to (or a | as a consequ | ence of): | | | | | | | | |
| Box 68 death certification of the ettending hed for use a vician/M | IF F 23b | EMALE: . Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcor 1 Live Birt 4 Pregnan 9 Unknow | h 2 ☐ Feta It at time of d | Ideath 3 🗔 | Ectopic pregna | ncy | | | | 23d. Date Month | | ery Day Year |
| ords, P.C requires that to been signed be should be detailed by Peter letted letter letter letted letter l | Par | t II. Other significant conditions of | | | | nderlying cause | given in Part | t I. | | | | | e cause of death? |
| Division of Vital Records, P.O. all or Attending Physician: The law requires that the start death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral or Be Completed by Physician Certificate: To Be Completed by Physician and the start of the completed by Physician and the start of the completed by Physician and the start of the s | _ | Failure to Advanced | Deme | ntia | | | | | 24a. Was auto perf 1 \(\sum \) Yes | DDSV | pric | or to con th? | osy findings available mpletion of cause of |
| clan: T | 25. | Was case referred to medical examiner? | | | | | Place of Dea | ath (Check | | 2 124 | NOT TE | 7 162 | 2 11 140 |
| n of Vij ding Physic h. After this of funeral dire tate: To | 27. | 1 Yes 2 No | Hospital: 1 ☐ Inp 28a. Date of i | | ER/Outpatien 28b. Time of | t 3 LJ DOA | | | me 5 🗆 Resi | | | Specify | |
| livision of attending P after death. Director: After til Jin by the funera | | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not | (Month, I | Day, Year) | injury | M 1 | rk? ☐ Yes 2 ☐ | _ [| 28d. Describe | how inju | ry occurred | | |
| Divisation At an all Direct led in by | | 4 Homicide determined | 28e. Place of building, | etc. (Specify) | | et, factory, office | | | City or To | wn, State | e) | | Route Number, |
| Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi Medical Certifica | | only one) 3 L Certifying Nu | niner: On the basis o | of examination | and/or invest | igation, in my opi | nion, death o | occurred at | the time, date | and plac | e, and due to | the cau | se(s) and manner stated. |
| To with | 29b | Signature and title of certifier | en 1 | no | | 29c. Licer | 002 | 295 | 71 | 29d. Da | ate signed ($^{6}/2$ | Month, E | Day, Year) 2 012 |
| 8 B | 30. | Name and address of person who | competed cause o | | 23a) (Type, P | nint) Defe | 750 | 4w) | v, Cr | of | ton. | me | 2012 221114 |
| State Registrar | 31. | Date filed (Month, Day, Year) JUN 2 7 2 | 012 32. Regis | strar's Signati | d. | ake | | | | =2/m | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 12:25 p.m. June 27 Willard James Baxter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice House of St. Mary's Callaway 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 267-90-1115 1 X M 2 □ F 11/16/1950 Pennsylvania 61 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20650 21734 Meadow Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ X Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Engine Inspector Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Catherine Smith Charles Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21734 Meadow Court, Leonardtown, MD Anita Baxter/Wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/03/2012 California, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St.Andrews Cemetery Brinsfield Funeral Home, P.A. MD 20650 22. Name and Address of Facility 21. Signature of Funeral Service License Danielle Ward M01403 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Chronic Kidney Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Atherosclerosis 10 years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 25 years Diabetes Mellitus and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialattending physician Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Pregnant at time of death the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Legally Blind 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No 1 Yes 2 XNo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 XNo Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural filled in by the funeral 28c. Injury at work? 28h Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one 29c. License number 29b. Signatu 29d. Date signed (Month, Day, Year) June 28, 2012 D31563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RME

Registrar DHMH 17 Rev 06-2011 Charles Benner, M.D.

JUN 2 8 2012

20945 Great Mills Road, Lexington Park, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2.2 Day 2.01^{Ye}2 Patsy Grace Bussard 6:10 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days **Director** 219-36-3846 70 1 M 2 XF 10/25/1941 MD Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 118 Locust Ct. 21769 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural". Completed 3 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ပ Leo Colliflower Thelma Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Locust Ct., Middletown, MD 21769 Bussard (Husband) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Larry E 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial ☐ Cren Lutheran cemetery 6/26/2012 Middletown, MD 5 Other (Specify) Donation meral St ²² Name and Address of Facility
Donald B. Thompson Funeral Home
POB 18, Middletown, MD 21769 ature of ice Lice E ter the diseas emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are Approximate Interval Between Once and Death shock, of heart failure. List only one of Immediate vause (Final disease or ondition re thin in death) Physician/ Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death the Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending nours after death.

neral Director: Aft
y filled in by the fur М 2 🗌 No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie JUNE 26 2012 26516 rson who completed cause of death (Item 23a) (Type, Print) PRIVE FREDERICK MD 21704 Gultond J (-1 SUN 7115 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Jan 27 1947 215-46-9307 Director Country) 1 🕅 M 2 🗆 F Jan 65 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 28a-f Odenton Mary1and Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 Hallock Dr. 21113 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 5 Black, White, etc. 1 Never Married 2 Married \$ 1 XYes If Yes, Give Maryland 21215-0036 hours after 2 No 1 ☐ Yes 2X No Specify: Specify: Completed 3 Divorced Year or Dates.1966-69 Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 and Mental Hygiene. is marked other than United States Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Custodian Posta1 Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 pe William G. Butler Sr Mary Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shated beath are Important: If item 27 is Tralene Johnson (Daughter) 114 Liason Ct. Odenton, Md. 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veteran injury or 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-18-12 Crownsville, Md. 21. Signature of Funeral Service Licenses Amane a Recens con Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, name 2 should be accounted. Cause (Disease o. mjur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, Statel Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 2 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ture and title of certific cause of reath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

JUN 15 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Linda Lee Broughton 12. June 2012 4:17pM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 262-96-4092 1 🗆 M 2 🕱 F 64 1947 Washington, D.C. Aug. 6, Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland must be notified at Director 10d. Inside City Limits Oueen Anne's Chester 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 106 Kirwans Landing Lane 21619 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black. White, etc. ō Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 Cosmetologist Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gloria Purner ည Ralph D. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 27 is Department of Health and Important: If item 27 i Chester, MD 21619 Woody Broughton/Husband 106 Kirwans Landing Lane 20a. Method of Disposition 20b. Place of Disposition (Name of June 14 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory 2012 Baltimore, MD Signature of Funeral Pervise Lice Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Part 1. Enter the disease, or complications that caused the death. Do not enter the shork, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disea e or condition recting in death) Medical **Examiner** Sequentially list conditions. Examiner If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ igned by the atter be detached for in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes 2 No Division of Vital the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Number Practitioner T. the best of hydroxyledge death occurred at the time, date and place, and due to the cause(s) and manner as tated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo ture 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Prir

Registrar
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31. Date filed (Month, Day, Year) JUN 15 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 Day 2012 June 7:00 A M Nelson S. Burke Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 1121 University Blvd West #408 Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** 1 X M 2 | F Director 93 579-05-6483 ulv 20. 1918 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director or 28a-f Silver Spring 1 Yes 2 No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1121 University Blvd West #408 20902 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o Completed by 1 Never Married 2 X Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates, 1944 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Labor Department and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Director for Civil Rights Federal Government 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Dutch Nelson Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20902$ 1 and 2 s if Health a item 27 i 1121 University Blvd West #408 Silver Spring, Md Barbara Patrick / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/22/12 Brentwood, Md Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Finance Surface Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, Md 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending pl IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant
Unknown Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has death? KIDNRY DISPER 1 ☐ Yes 2 ☐ No __ Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director. After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Funeral C Medical 29a. Certifier Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signat 29c. License number 0 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Jeffery

Westone

Silver Spring, Md

20904

12201 Plum Orchard Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Arthur Beall 20 7:20 A M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Care and Rehabilitation Ctr Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months **Director** 86 218-24-2971 3 1926 Maryland June Usual Residence of Decedent show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits te within 72 hours after death with the Maryland Director r 28a-f sh notified a 1X Yes 2 ☐ No Prince George's Glenn Dale Md 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 20769 6125 Bell Station Rd USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Year or Dates Specify: White "natural". 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Security Guard and Mental Hygier is marked other Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grover C. Beall Viola C. Harvey traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 / Sister Department of Health Important: If item 27 any injury or other the once. Edna Abell 6215 Bell Station Rd Glenn Dale, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 6/25/12 Brentwood, Md Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home Xeta hances 3401 Bladensburg Rd Brentwood, Md 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perfor 2 🗌 No Yes To the Funeral Director; After this certifical completed filled in by the funeral director; if Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: မ 1 Yes Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work' Natural 1 \(\text{Yes} 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours Medical 1.X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) OOGALLANTFOXLN#222, BOWIEMD20715 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4^{Day} $\overset{Month}{JuIv}$ 2012 1920 Рм Eleanor T. Cook Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 1 F Days Hours Min SEPTh, Gy, Year 913 Director 161-20-2026 98 Maryland Usual Residence of Decedent I Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Jarmon Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hostess Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file.
I and Mental H
Is marked ot Frederick J. Troll Ida Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Betty Jane Andrew/Daughter Post Office Box 21, Elkton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any Injury or X Burial 2 Cremation 3 Removal from State July 2012 Stevensville Cemetery 4 Donation 5 Other (Specify) Stevensville, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death theimer) Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a co sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 I Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 9un 5114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 lew's las State Registrar

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 45 M 4onth Physician/ Gordon Augustus Crandall, Jr. lune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Shady Side 1254 Steamboat Rd. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Mir 218-28-1456 **Director** 84 1XXM 2 □ F 8/31/1927 DC Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director Shady Side 1 Yes XX No MD Anne Arundel 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral USA must 1254 Steamboat RD. 20764 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married Married 1 ☐ Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XX No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.

7 is marked other than "natur". 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Marine Contractor Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella E. Placide Gordon A, Crandall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trac 1 and 2 s of Health 1254 Steamboat Rd. Shady Side, MD 20764 Wife Jean Crandall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 6/30/2012 Galesville, MD Woodfield Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Softice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 78 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on the line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ArkINSON'S disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed should I . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: eral Director: After I filled in by the funer Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 2ga Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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Name and address of person who complete

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use of death (Item 23a) (Type, Print)

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Registrar's Signaty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Kellis Byron Collins, Jr. 2012 12:30 June Medical 4a. Facility Name (if not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Cecil 82 Cecil Street Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign 6. Sex Funeral (Month, Day Year) ec. 13. 1938 Hours Country) Maryland 1 🔀 M 2 🗆 F 214-36-8112 74 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Charlestown Maryland Cecil 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21914 U.S.A. 82 Cecil Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. American 2 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Indian Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unknown Well Driller Construction unknown Be permit. Page 1 and 2 should be filed Department of Health and Mental Hyy Important: If item 27 is marked othe 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ဂ Gladys Smith Kellis Byron Collins, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Collins Long Beach Dr., Charlestown, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06/28/12 Wilmington, Delaware Silver Brook Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Lices homas M Perryville, 21903-0766 Maryland 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death EBRO Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Box in the past 12 months?
1 ☐ Yes 2 ☐ No Ę Month Year 5 Other (specify) Pregnant at time of death be detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Records, 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury To the Hospital or Attending 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number pleted cause of death (Item 232 (Type, Print) 30. Name and address of person who con RD STE 211 ORN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registar's Signature

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claud Franklin Clark June 2012 5:10P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Charlotte Hall Veterans Home Mary's Charlotte Hal If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Months 410-10-2176 1 X M 2 D F **Director** 96 Yrs. 02/23/1916 Tennessee Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Director MD 1 Yes 2 No St. Mary's Charlotte Hall 10e. Street and Number 10f, Zip Code 0 10g. Citizen of What Country? Funeral items 23a 29449 Charlotte Hall Road 20622 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ori þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 72 hours after If Yes, Give White 3 Widowed 4 N Divorced "natural", Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Insurance Claims Adjuster Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Daniel Clark Lucy Louise Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Sharon M. Mattia / POA 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 permit. Page 1 and 2 Department of Healt Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State injury o 4 Donation 5 Other (Specify) Brinsfield-Echols Crem 06/22/2012 Charlotte Hall, MD . Sign Jux of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 4M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
5 vears Immediate Cause (Final Physician/ disease or condition resulting in death) years a Alzheimer s/Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician s the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Dav Pregnant at time of death 1 Yes 2 No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Chronic Obstructive Pulmonary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Disease, and Hyperlipidemia 24a Was an autopsy performed? 1 ☐ Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No ours after death leral Director: A filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Sta

30 Name and address of person who comple Dr. Stephen Cafferty 29449 Charlotte Hall

31. Date filed (Month Car, Year) 2012

Charlotte Hall, MD 20622

ompleted cause of death (Item 23a) (Type, Print)

Registrar's Signat

Rd.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 4 | | artment of Health a | ınd Mental Hy | giene | 10 00076 |
|----------------------------|---|--------------|---|---|--|--|---|--|
| | - | | State Registrar | Cer | tificate of Death | | Reg. No. 2 U | 12 22316 |
| п | Physicia | ın/ | 1. Decedent's Name (First, Middle, Last) Benedict Ignatius Clarke | | | Date of De Month | eath Day | 3. Time of Death |
| بالمعاقر | Medic | al | Benedict Ignatius Clarke 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of | June | 25 Day 2012 | |
| | Examin | er | 43740 Sandy Bottom Road | | Hollywood | Deam | 4c. County o | |
| ¥. | Funeral | | | yrs. last birthday) | If Under 1 Year If Under 2 | | th | 9. Birthplace (State or Foreign |
| | Director | | | 7.5 Yrs. | Months Days Hours | Min. (Month, Da | | Country) Maryland |
| | nd how at | <u>_</u> | Usual Residence of Decedent 10a. State 10b. County 10 | c. City, Town or Lo | cation | 100, 10 | ., _, | 10d. Inside City Limits |
| | laryla 3a-f s iified | Director | Maryland St. Mary's | Hollywoo | d | | | 1 ☐ Yes 2 🗹 No |
| | the N | | 10e. Street and Number | | 10f. Zip Code | Ì | 10g. Citizen of W | hat Country? |
| | is 23a nust b | Funeral | 43740 Sandy Bottom Road | | 20636 | | United S | tates |
| | death ritem nern | Fui | 11. Marital Status 12. Was Decedent Ever Armed Forces? | in U.S. 13. V | Was Decedent of Hispanic Origi f Yes, specify Cuban, Mexican, | in? (Specify Yes or No- Puerto Rican, etc.) | 1 11 11000 | - American Indian, , White, etc. |
| 36 | al", o | d by | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Very or Dates | 1 | I ☐ Yes 2 No Specify: | | Specify: | White |
| 9 | e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | 15. Decedent's Education | | dent's Usual Occupation | | 16b. Kind of Bus | |
| 218 | in 72 e. nan "ı | duc | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Give I | kind of work done during most o O NOT use retired) | of working | | |
| 2 | ed with Hygien other ti e nt, the | Be C | 8 | Farme | | | Agricul | tural |
| Maryland 21215-0036 | ntal Hyged other: | To B | 17. Father's Name (First, Middle, Last) | | | 's Name (First, Middle, | | |
| Ž | 2 should be file Ith and Mental I 27 is marked o traumatic eve | Ė | George Clarke 19a. Informant's Name/Relationship (Type, Print) | 10h Mailin | Helen | | | at 7'- 0-d-\ |
| | | | Ida E. Clarke-Daughter | E . | th Street, Lot | | | |
| re, | je 1 and 2 t of Healt If item 2 or other 1 | | 20a. Method of Disposition 2 | Ob. Place of Dispo | sition (Name of | Date | | Dity or Town, State |
| Ë | Page 1 ment of ant: If it ury or o | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Brinsfiel | natory or other place) d-Echols 06 | 5/29/2012 | Charlott | e Hall, Marylan |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service Lice Kathleen A. Santivasci MOO | 22 | . Name and Address of Facility | Brinsfield | l Funeral | Home |
| | 40 = 60 | | Kathleen A. Santivasci MOC 23a. Part 1. Enter the disease, or complications that caused the | | | | | Maryland 20650 |
| | | | shock, or heart failure. List only one cause and line. Immediate Cause (Final | death. Do not ente | 1 1 - | | rest, | Approximate Interval Between Onset and Death |
| inte | Physician/ Medical | | disease or condition resulting in death) a. Due to (or § a cor | MIN H | east Falus | e | | Onot and Board |
| | Examiner | | DEC | isequence oi). | | | | |
| | + | iner | if any, leading to immediate cause. Enter Underlying Due to (or as a con | nsequence of): | | | | |
| | cuted | Examine | Cause (Disease or injury that initiated events c. | | | | | |
| | cate be executed physician and s the burial-transit | alE | resulting in death) Last Due to (or as a con | isequerice oi). | | | | |
| 760 | death certificate be executed ne attending physician and ed for use as the burial-transi | ledical | d | | | | | |
| 89 | certif nding use a | In/N | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pr | |] F. (| | 23d. Date | of delivery |
| Box 687 | death le atte | Physician/M | in the past 12 months? 1 | | Other (specify) | | Mont | th Day Year |
| P.O. | requires that the death certific been signed by the attending p should be detached for use as | Phy | g Unknown Part II. Other significant conditions contributing to death but no | at requiting in the u | ndovlujna sausa ajuan ja Dort I | 00 8:44 | | |
| Ф. | es tha | d by | Factili. Other significant conditions contributing to death but he | or resulting in the di | indenying cause given in Fait i. | 23e. Dig ti | | bute to the cause of death? |
| ırdş | requir been should | etec | | | | 24a, Was | | ere autopsy findings available |
| ecc | sician; The law receiving the second | Completed | | | | auto | psy pri | ior to completion of cause of eath? |
| E E | an; Th tificate tor, pe | Be Co | 25. Was case referred to medical | | 26. Place of Death | 1 Yes | 2 ≥ No 1 l | Yes 2 No |
| Vita | ysici lis cer direc | To B | examiner? 1 Yes 2 No Hospital: 1 Inpatient | — 2 □ ER/Outpatien | Inther: | sing Home 5 Resid | dence 6 🗆 Other | (Specify) |
| of | ing Pl | | 27. Manner of Death Natural 5 Pending Accident Investigation 28a. Date of injury (Month, Day, Yea | 28b. Time of injury | 28c. Injury at work? | 28d. Describe | now injury occurred | 1 |
| ion | ttend death tor; A / the f | Certificate: | 3 Suicide 6 Could not be | A4 h | M 1 Yes 2 N | | | |
| Division of Vital Records, | al or Attending F s after death. I Director; After t ed in by the funer: | Cer | 4 Homicide determined 28e. Place of Injury - building, etc. (Sc | At nome, farm, stre pecify) | еет, тастогу, опісе | 28f. Location (S | | or Rural Route Number, |
| | To the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach | Medical | 29a. Certifier 1 Certifying Physician: To the best of my k | nowledge, death o | occurred at the time, date and p | lace, and due to the ca | ause(s) and manner | r as stated. |
| | the Horin 24 the Full Horizontal Inches | Mec | (Check 2' Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practitioner: To the best | nation and/or invest st of my knowledge, | igation, in my opinion, death occi death occurred at the time, date | urred at the time, date a and place, and due to t | and place, and due t the cause(s) and ma | o the cause(s) and manner stated. nner as stated. |
| | To To To To To To To To To To To To To T | | 29b. Signature and title of certifier | | 29c. License number | 2-5-1 | 29d. Date signed (| |
| J | | | - YUUNO | | 1055 | 751 | 00-2 | 7-2012 |
| 10 | me | | 30. Name and address of person who completed cause of death | | _{rint)} nts Lane, Suite | o 205 Too | nardtarm | MD 20650 |
| | Stat | е | | | | e 200, Leo | naru LOWII, | , rm 20000 |
| | Registra | ir | JUN 2 8 2012 | signature for | Ke - | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For | State | of Marylar | • | | lealth and N | ∕lental Hyg | giene | | |
|-----------------|---|--------------|--|---|-----------------------------|---------------------|--|---|-----------------------------------|-----------------|------------------------|-----------------------------------|
| | | | State Registrar | | <u> </u> | Cer | tificate of D | Death | | Reg. No. 2 | 012 | 22377 |
| | Physicia | n/ | Decedent's Name (First, Middle, TANKE OF TANKE) | , | | | | | 2. Date of Dea Month JUNE 2 | Day | 01 ^{Year} | 3. Time of Death |
| | Medic | al | JANICE LYNN 4a. Facility Name (if not institution, | COHEN | nher) | | 4b City Town or | Location of Death | JUNE 2 | | | 8:40 A M |
| | Examin | er | WASHINGTON ADVI | | | | TAKOMA | PARK | | | ty of Death | Y |
| | Funeral | | | 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birtl | 1 | 9. Birthp | lace (State or Foreign |
| | Director | | 217-70-3263 | 1 □ M 2 🖾 F | 52 | Yrs. | MOITHS Days | Hours Mill. | (Month, Day | | Count | SC SC |
| | nd how at | or | Usual Residence of Decedent 10a. State 10b. County | | 10c. Ci | ty, Town or Loc | ation | - | | | 11 | 0d. Inside City Limits |
| | Aaryla 8a-f s tified | Director | MD PG | | CAP | ITOL HE | IGHTS | | | | | 1 🛣 Yes 2 □ No |
| | the h | I Dii | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Coun | try? |
| | ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" or items 25a or or 28a-f show marke event, the Medical Examiner must be notified at | Funeral | 6864 WALKER MIL | L RD #30: | 2 | | 20 | 743 | | US | | |
| | r iten | | 11. Marital Status1 ☐ Never Married 2 ☐ Marri | Armed Fo | edent Ever in U. prces? | | las Decedent of His Yes, specify Cuba | spanic Origin? (Spe n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | ce - America | |
| 36 | s after al", o Exam | d by | 3 XWidowed 4 Divorced | ed 1 ☐ Yes If Yes, Giv Year or D | /e | 1 | ☐ Yes 2 No | Specify: | | Specif | y: BLA | CK |
| 5 | hour natur dical | Completed | 15. Deceden (Specify only highes | t's Education | | 16a. Deced | ent's Usual Occupa | ation | | 16b. Kind of I | Business Ind | lustry |
| 21215-0036 | nin 72 ne. than " e Me | Juo | Elementary/Seconday (0-12) | College (1 | _ | life. DC | NOT use retired) | uring most of work | ng | DDTII | | |
| 2 | d with tygier ther t | Be C | 17. Father's Name (First, Middle, La | | | NURS | E AIDE | | | PRIVA | | |
| Maryland | be filed wit lental Hygier rked other i ic event, th | 70 E | EUGENE COHEN | istj | | | | 18. Mother's Nam | | Maiden Surnan | ne) | |
| ar _Z | should I and Me is marl raumati | | 19a. Informant's Name/Relationsh | p (Type, Print) | | 19b. Mailin | a Address (Street a | SARAH R3 | | City or Town. | State, Zio C | ode) |
| | 7 ± 2 ± 5 | | TIM COHEN/SON | | | | | | | | . , | MD 20743 |
| ore | ige 1 and nt of Heal t: If item | | 20a. Method of Disposition 1 □ Burial 2 X Cremation | 3 | | Place of Dispos | | | Pate 2 | 20c. Location | - City or To | wn, State |
| Ĕ | Page tment o tant: If tant: If jury or | | 4 Donation 5 Other (Sp | | Jiaie | ERDALE | PARK CRE | MATORY | | RIVERDA | | |
| Baltimore, | permit. Page 1 Department of Important; If I any injury or once. | | 21. Signature of Funeral Service Li | ce Aee | 01010 | and the second | | s of Facility POI | | | | |
| | | 1 1 | 23a. Part 1. Enter the disease, or | complications hat | | | | ORO PIKE | | | MD 20 | 0747 Approximate |
| ı, | | 0.0 | shock, or heart failure. List or Immediate Cause (Final | nly one cause on ea | ch line. | * | | y odom do odrado e | n respiratory and | , | | Interval Between Onset and Death |
| | Medical | | disease or condition resulting in death) | a. Due to | or as a conseq | uence of): | | | < | | | |
| | Examiner | | On wordfalls link and distant | 10 | | | | my Dise | afe | | | |
| | 7 ± | iner | Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying | Ο. | or as a conseq | | | | | | | |
| | executed an and rial-transi | Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | C. Due to | or as a conseq | uence of | | | | | | |
| | ate be executed physician and the burial-transit | dical E | resulting in death) Last | | or as a conseq | dende on. | | | | | | |
| 9 | icate l phys | ledic | | d | | | | | | | | |
| 200 | certif ending use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | | come of pregna | | Ectopic pregnancy | , | | 23d. D | ate of delive | ry |
| ROX | death ne atte ed for | sicia | in the past 12 months? 1 Yes 2 No | | nant at time of | | Other (specify) | y | · | М | onth | Day Year |
| 7. O | at the | Phy | 9 ☐ Unknown Part II. Other significant condition | | | culting in the ur | derlying cause give | en in Part I | one Didas | | | |
| ν. 7. | es tha | d by | Tartii. Other significant condition | is contributing to d | catt but not to. | saiding in the di | denying cause give | on in rait i. | | es 2 🗆 No | ~/ | e cause of death? ably 4 Unknown |
| ğ | requir been should | ete | | | | | | | 24a. Was a | | _^ | sy findings available |
| Vital Records, | e has | Completed | | | | | | | autops perfor | sy | prior to con death? | npletion of cause of |
| <u> </u> | an: Th tificate tor, pa | Be Co | 25. Was case referred to medical | 1 | | | 26. Pla | ice of Death (Check | | 2 No | 1 Yes | 2 No |
| <u> </u> | nysicia lis cer direct | To B | examiner? 1 Yes 2 No | Hospital: | Inpatient 2 | ER/Outpatient | Lothe | 1.0 | | ence 6 🗆 Oth | ner (Specify) | 1000 |
| ō | ng Pł fter th ineral | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date (Mon | of injury th, Day, Year) | 28b. Time of injury | 28c. Injury work? | at | 28d. Describe ho | w injury occur | red | |
| O C | ttendi death tor: A the fu | Certificate: | 2 Accident Investign 3 ☐ Suicide 6 ☐ Could n | ation of he | | | | Yes 2 No | | | | |
| DIVISION OF | l or At after of Direc | Cer | 4 Homicide determin | | ng, etc. (Specif | | et, factory, office | | 28f. Location (St City or Town | | per or Rural I | Route Number, |
| ב | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physicic completed filled in by the funeral director, After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burn | Medical | | Physician: To the b | | | | | | | | |
| | he Ho iin 24 he Fu ipleted | Med | | aminer: On the bas Nurse Practioner: | | | | | | | | se(s) and manner stated. ted. |
| _ | Not the com | 7 | 29b. Signature and title of certifier | 1 | | | 29c. License | * 3 | 2 | 9d. Date signe | | |
| | 2 | | 1 | MID | | | 069 | 194 | | 6-2 | 5-1 | 2 |
| | 44 | | 30. Name and address of person w | | e of death (Iten | - | | takona | Park 1 | 111 | | |
| | Stat | e | 31. Date filed (Month, Day, Year) | | egistrar's Signa | ture , | 11116 | I we oriet | bark ! | 11) | | |
| | Registra | | JUN 2 8 2012 | Denous) | egiatrar's Signa | W. | | | | | | |

| 2-04788 | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. | | | | | | | | | | | |
|--|--|--|--|---------------------|-------------------------------|------------|----------------------------------|-----------------------------------|----------------------------------|-----------------|------------------------------|--|
| ames Eric Cain | | State of Maryland / Department of Health and Mental Hygiene 2012 223 | | | | | | | | | | |
| | | 1- For State Registrar | | Cer | tificate | of Dea | ath ——— | | 10.0 ((0 | Reg. No. | | |
| Physicia Medical Exami | | 1. Decedent's Name (First, Midd JAMES ERIC CA | AIN | | | | | | 2. Date of D Month June 25 | , 2012 | Year | 3. Time of Death 2131 hrs |
| | | 4a. Facility Name (if not institution Prince George's Hosp | | umber) | | | y, Town, or Li e verly | ocation of Dea | th | | c. County of D Prince Geo | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. la | ast birthday) | | nder 1 Year | If Under 24H | rs. 8. Date of | Birth(MM | DD/YYYY) 9 | . Birthplace (State or preignSOUT h |
| Director | | 578-80-7040 | 1 M 2 F | 5 | 3 Y | rs. Mor | nths Days | Hours M | 02/15 | | | Country)Carolina |
| | | Usual Residence of Decedent | | 140. 00 | | in a | | | | | | |
| ow any | | 10a. State 10b. County | | | Town or Loc | | | | | | | 10d. Inside City Limits 1 X Yes 2 No |
| Aaryland 28a-f show 1 at once. | ţċ | DC None 10e. Street and Number | | Was | hingto | | Zip Code | | | 10a Citi | zen of What | |
| or 28 | Director | 4421 Quarles S | Street NE | | | | 20019 | | | US | | |
| death with the Maryland or items 23a or 28a-f sho must be notified at once | | 11. Marital Status | | cedent Ever in U. | S. 13. V | | | anic Origin? (| Specify Yes or | | | merican Indian, Black, |
| death | Funeral | 1 Never Married 2 M | arried Armed F | orces? | H | Yes, spe | ecify Cuban, I | Mexican, Puer | to Rican, etc.) | | White, et | c. |
| after al", n | D. F | | orced If Yes, Give Yes | er | - | | 2 X No | | | | <u> </u> | Black |
| hours natu | | Decedent's Education (Spe Elementary/Secondary (0-12) | | | during | most of v | | on (Give kind or DO NOT use re | | 16b.) | Kind of Busine | ess/Industry |
| hin 72 hin 72 ee. | Completed | 9th | Conces | 1-401017 | Mecha | nic | | | | P | rivate | |
| 5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner | | 17. Father's Name (First, Middle | , Last) | | | | 18 | | ne (First, Middle | | Surname) | - |
| 21215-0036 ould be filed within 7 i Mental Hygiene. I marked other than ic event, the Medica | o Be | James S. Cain 19a. Informant's Name/Relations | thin (Type Print) | | 19h Mail | na Addre | es (Street | | e Wilso | | ity or Town S | itate, Zip Code) |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a or 28a-f she injury ar ather traumatic event, the Medical Examiner must be notified at once | ř | Pauline Cain/Mo | | | 4421 | Qua | rles S | Street | NE Wash | ningt | on, DC | 20019 |
| ore, s l an of Heal If iten | | 20a. Method of Disposition 1 X Burial 2 Cremation | n 3 Removal fr | rom State | Place of Disp crematory or | other plac | ce) | | Date | | | y or Town, State |
| Page ment c | J. | 4 Donation 5 Other S | pecify: | На | - | | | | /02/201 | | - | |
| Baltimore, permit. Pages I at Department of Her Important: If ite injury ar ather tr | | 21. Signature of Funeral Service | Licensee | 1 | | | | | rs a - d Suitl | | | ra Pome 746 |
| Physician | | 23a. Part I. Enter the disease, or failure. List only one cause | | aused the death. | Do not enter | the mod | le of dying, su | uch as cardiac | or respiratory a | arrest, sho | ock, or heart | Approximate Interval Between Onset and |
| /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | Death |
| and the second s | 1 | | Due to (or as a | consequence of |): | | | | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | consequence of |): | | | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last | С. | consequence of |): | | | | | | | |
| kecuted and transit | | g, = | d | | | | | | | | | |
| ज्ञ ह | dical | UNPENDED | AMENDED | | | | | | | | | |
| Box 68760, e death certificate be the attending physical for use as the burst of for use as the burst of the second control of the control of | cian/Medi | IF FEMALE: 23b. Was decedent pregnant in th | 23c. If yes, | outcome of pregr | | etal deat | th 3 | Ectopic pregr | ancu | 230 | d. Date of deli Month | very Day Year |
| ox 687 eath certific attending | Cia | past 12 months? | 4 Pregr | nant at time of dea | ath - | Other (Sp | | _Lotopic progi | larioy | | Monar | Day Tour |
| BO) e deatl the atl | Physi | | known 9 Unkno | | | | | | | | | |
| i, P.O. ires that the signed by I be detach | b P | Part II. Other significant condit | ions contributing to | o death but not re | sulting in the | underlyi | ng cause giv | en in Part I. | | | | e to the cause of death? Probably 4 Unknown |
| quires en sign | | | _ | | | | | | 24a. Wa | | | e autopsy findings available |
| Records, The law requir fificate has been s | Completed | | | | | <u> </u> | | | aut | opsy formed? | | to completion of cause of |
| ital Recician: The sector, page | ទ | | | | | | | | 1 ✓ Yes | 2 N | 0 1 🗸 | Yes 2 No |
| ician: | Be | 25. Was case referred to medica examiner? | 4.4 | Inpatient 2 | FR/Outpatie | nt 3 | | f Death (Check | ing Home 5 | Reside | nce 6 0 | ther: |
| fing Physics After this funeral dir | <u>۽</u> | 1 ✓ Yes 2 No 27. Manner of Death | Isea Data | of Injune | 28b. Time o | | 28c. Injury | | 28d. Describ | e how inju | ıry occurred | |
| Division of Vital tal or Attending Physician rs after death. al Directur: After this cert led in by the funeral director | rtification: | 1 Natural 5 Pend 2 Accident Inves | fOUND stigation Jun 25, | Day,Year) | FOUND: 2047 hrs | | 1 Yes | s 2 🗸 No | Subject cu | it and s | tabbed | |
| Divisi pital or Att ours after de teral Direct filled in by | | 3 Suicide 6 Coul | d not be 28e. Plac | e of Injury - At ho | me, farm, str | eet, facto | ry, office buil | lding, etc. | 28f. Location or Town | | nd Number or | Rural Route Number, City |
| Spital hours a neral | 3 | 4 Homicide | rmined (Specify) | | | | | | 1530 Kenilw | orth Ave | NE, Wash | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Directur: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn | Medical | Contour only | hysician: To the bes miner:On the basis and manner s | of examination ar | | | | | | | | |
| | Æ | 29b. Signature and title of certifie | | | - | 2 | 9c. License r | number | | 29d. I | Date signed (| Month, Day, Year) |
| 3 | | totalle | - Pal | 0,,,, | | | O.C.M. | .E. | | Jun | e 26, 2012 | ? |
| U4 1 | 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD — Assistant Medical Examiner 900 W. Baltimore Street. Baltimore, MD 21223 | | | | | | | | | | | |
| | - 1 | Patricia Aronica-Poliai | KIVII J. ASSIST | antiviedical F | xaminer | 900 V | v naiimo | ne orreet | pailimore i | VILJ Z 12 | 23 | |

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar JUN 2 8 2012

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | For State | State of Ma | aryland / | | | | Mental Hy | giene | | |
|---------------------------------|--|------------------|--|---|---------------------------------------|-------------------|---|-------------------------------|-------------------------------------|------------------|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle | . Last) | · | Cer | tificate of L | Jeatri | 2. Date of De | Reg. No. | 012 | 22376 |
| | Physicia | | Susan Maralyn | • | | | | | | Day | 202 | 7:25 M |
| | Medic Examin | | 4a. Facility Name (if not institution, | | | | 4b. City, Town, or | Location of Deat | h O | 4c. Count | ty of Death | |
| | | | Meritus Medic | al Center | | | Hagerst | | | Wash | ningto | n |
| | Funeral Director | | 215-74-8412 | 6. Sex 1 ☐ M 2 🖾 F | e (In yrs. last b | virthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | 8. Date of Birt 02/02/ | | Count | lace (State or Foreign ry) yland |
| | nd how at | ř | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | wn or Loc | ation | | | | 10 | Od. Inside City Limits |
| | faryla 3a-f s tified | Funeral Director | Maryland Washi | ngton | Hager | stow | n | | | | | 1 🔀 Yes 2 🗆 No |
| | the N or 2 | <u>o</u> | 10e. Street and Number | J | | | 10f. Zip Code | | | 10g. Citizen of | What Count | try? |
| | n with | nera | 1382 Marshall S | Street | | | 21740 | | | U.S.A | • | |
| 36 | Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at | þ | 11. Marital Status1 ₭ Never Married 2 ☐ Marr3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | | If | /as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No | n, Mexican, Puer | pecify Yes or No- o Rican, etc.) | Bia | ice - America ack, White, e ^{(y:} Whit | tc. |
| 8 | hours natura ical E | lete | 15. Deceden | Year or Dates. | 16 | Ba. Deced | ent's Usual Occup | ation | | 16b. Kind of I | | |
| 21215-0036 | in 72 h | Completed | (Specify only higher Elementary/Seconday (0-12) | st grade completed) College (1-4 or 5 | | (Give k | ind of work done of NOT use retired) | | rking | TOD. KING OF | Ju 3111633 1110 | иопу |
| 7 | J with ygiene her th | | 0 | | | | | Never wo | rked | N/A | | |
| and | l be filed fental Hyg rked oth | To Be | 17. Father's Name (First, Middle, L. | , | | | 100 | | me (First, Middle, Austrow | Maiden Surnan | ne) | |
| Ĕ | should be file and Mental F 7 is marked o raumatic eve | | Stephen DeSall 19a. Informant's Name/Relationsh | | 10 | Ob Mailin | g Address (Street a | | | - City on Town | Chaha Zia O | a dal |
| Š | d 2 sh alth ar 27 is r trau | | Sarah Kendrick | | | | Marshall | | | | | |
| Jre, | of Hear of Hear fitem | | 20a. Method of Disposition | | 20b. Place | of Dispos | sition (Name of atory or other plac | | Date | 20c. Location | | |
| <u>=</u> | Page ment ant: It ury or | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) | | | Have | n Cemete | ry 7/6 | | | | Maryland |
| Baltimore, Maryland | permit. Page 1 Department of Important: If it any injury or c | | 21. Signature of Funeral Service Li | icensee | | | Name and Addres | | | | | - |
| | 40 = 6 O |) A | 230 Part 1 February discourse or | Ab | the death De | | | | | | , Mary | 1and 21742 |
| | Pnysician/ | | 23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition | nly die cause i each line | wo M | ia | r the mode of dying | g, such as cardiad | or respiratory arr | est, | | Approximate Interval Between Onset and Death |
| | Medical Examiner | | resulting in death) | Due to (or as a | consequence | e of: | 1.10 6 | O.L. | | | |) V |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Jue to (or as a | consequence | e oij. | man | erry | | | | 107 |
| | uted Id ansit | Examiner | cause. Enter Underlying Cause (Disease or iinjury that initiated events | G | | | | | | | | |
| | exec ian an irial-tr | Ě | resulting in death) Last | Due to (or as a | consequence | e of): | | | | | | |
| 9 | cate be executed physician and the burial-transit | edical | | d | | | | | | | | |
| 687 | ertifica ding p | /Me | IF FEMALE: | 23c. If yes, outcome of | of pregnancy | | | | | | | |
| Box 687 | ath c | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No | | 2 🗌 Fetal dea | | Ectopic pregnance Other (specify) | у | | | ate of deliver onth I | y Day Year |
| ш С | the di by the achec | hys | 9 Unknown | g 🗆 Unknown | | | | | | | | |
| <u>.</u> | s that gned | ρ | Part II. Other significant condition | ns contributing to death bu | ut not resulting | g in the ur | iderlying cause giv | en in Part I. | | | | cause of death? |
| rds, | equire een si ould b | ted | | | | | | | 1 🗆 ነ | Yes 2 No | 3 Prob | ably 4 🗆 Unknown |
| ō S | law n has b e 2 sh | Completed | | | | | | | 24a. Was a autop | | Were autop: prior to com death? | sy findings available pletion of cause of |
| Ä | sician: The law r certificate has b lirector, page 2 sk | | 25. Was case referred to medical | | _ | | | | 1 🗆 Yes | | 1 Yes 2 | 2 □ No |
| /ita | siciar s certil | To Be | examiner? 1 Yes 2 No | Hospital: | ent 2 🗆 ER/C | Dutantiont | Othe | ace of Death (Che | | | (0) | |
| of | g Phy er this reral d | | 27. Manner of Death | 28a. Date of injur | y 28b. | . Time of | 28c. Injury | at | lome 5 Resid | | | |
| on | endin- sath. or: Aft he fur | ficat | 1 Natural 5 Pending 2 Accident Investig | ation | rear) | injury | M 1 □ | ? Yes 2 □ No | | | | |
| Division of Vital Records, P.O. | or Atto | Certificate: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi | | ry - At home, f . <i>(Specify)</i> | farm, stree | et, factory, office | | 28f. Location (S City or Town | | er or Rural F | Route Number, |
| | To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as | | 29a. Certifier 1 Certifying | Physician: To the best of r | ny knowlodeo | death | cured at the time | date and place | and due to the as- | iee(e) and ma- | ner an otata - | |
| | e Hos n 24 hi e Fun | Medical | (Check 2 Medical Ex | xaminer: On the basis of ex Nurse Practioner: To the basis | amination and | or investig | gation, in my opinio | n. death occurred | at the time, date ar | nd place, and du | e to the caus | se(s) and manner stated. |
| | To th withir To th comp | | 29b. Signature and title of certifier | 3.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7 | | | 29c. License | | | 29d. Date signe | ed (Month, D | ay, Year) |
| | 1.0 | | | - Res | | | 0 | 5232 | 3 | 07-0 | 2-20 | 12 |
| | , Our | | 30. Name and address of person w | | | | int) | | | | | 21140 |
| | Clas | | Mwammad 31. Date filed (Month, Day, Year) | | D | 266 | Spal Co | JUST, | Hagers | itaus, | MD | ×1140 |
| | Stat Registra | | JUL 1 6 20 | 12 Anexa | A. A | bark | | | - | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a per med cert G929 7/23/12 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25 June 11:30A M 2012 Martha Dale Ferne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year Feb. 23, **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. **Director** 220-32-5937 1 □ M 2**X** F 74 1938Virginia Usual Residence of Decedent 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Myersville 1 Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 10026 Wolfsville Road 21773 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Investment marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Properties Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental F ည John Ralph Clayton Annie Lee Thompson should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21773$ S permit. Page 1 and 2 st Department of Heath ar Important: If item 27 is any injury or other trau John C. Dale - Son 10026 Wolfsville Road, Myersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Depation 5 Other (Specify) Metropolitan Crematorium 6/26/12 Alexandria, Virginia 21. Sign ture of F neral Service Lice 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home hovers 26401 Ridge Road. Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final brain Physician! anoxic dameye disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** a meri Cardiae Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or Cause (Disease or injury that initiated events Respiratory Distress burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 attending pl IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year ed by the a 9 Unknown 9 Unknown Records, P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 N To the Hospital or Attending Physician; The this certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ျ 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 070926 6/11/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 a.75 1. 41701 fridered no 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year June 3:08 A. M Ruth Dendy M. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2011 Kent Village Drive Landover Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 😾 Months Days Hours Min. 93 Director 577-12-1577 Wash. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 Eastern Ave., N.E. 20019 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black 3 HWidowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Census Bureau Elementary/Seconday (0-12) College (1-4 or 5+) U.S.Government yrs. Unknown Be t, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) William Mavritte Addie G. Seldon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard C. Mavritte/Nephew 5022 E. Capitol St., N.E., Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cem. 06/28/12 Suitland, Maryland 22. Name and Address of Facility hington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee W. CC0316 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Cardiovascular Disease vrs Medical Due to (or as a consequence of): Examiner Dementia 10 vrs Sequentially list conditions, Due to for as a gunsequence of cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidarous, M.D.

31. Date filed (Month, Day, Year)

2 6 201

D45365

11701 Livingston Road # 101, Ft. Washington, Md. 20744

June 22,2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | For State | Pleas | e Type or Pri State of M | | d / Dep | artme | ent of F | Health and | | | _ | ible. | 0000 | 7 (|
|--|-------------------|--|----------------------------------|---|---------------|--|-------------------|---------------------------------|--|-------------------------------------|----------|--------------|----------------------------------|---|----------|
| | | Registrar 1. Decedent's Name | e (First, Middle, I | ast) | | Ce | rtifica | te of L | Death | 2. Date of De | Reg. N | to. 2 | 112 | 3. Time of Death | 3 |
| Physicia Medic | | Sallie | | Davidson | | | | | | June 2 | | 2012 | Year | 2:00 P | M |
| Examir | | 4a. Facility Name (if | not institution, g | ve street and number) | | | | - | r Location of Deat | า | 4 | lc. County | | | |
| Funeral | P | HCR Mar 5. Social Security No | nor Care | Sex 7. Aq | e (In vrs. la | ast birthday) | | nevy ler 1 Year | Chase I if Under 24 Hrs | 8. Date of Bi | rth | Mon | t gome | ry lace (State or Foreig | |
| Funeral Director | | 577-38-2 | | 1 □ M 2 🂢 F | 86 | Yrs. | Month | | Hours Min. | June 2 | ay, Year | 925 | Count | ginia ginia | 11 |
| nd now at | ١ | Usual Residence of 10a. State | Decedent 10b. County | | 10c. Cit | y, Town or L | ocation | | | | | | 11 | Od. Inside City Limits | <u> </u> |
| farylar Ba-f sl tified | ecto | Maryland | Montgo | mery | 1 | lver | | ng | | | | | | 1 🗗 Yes 2 🗆 N | |
| a or 2 be no | Funeral Director | 10e. Street and Num | nber | | | | 10f. 2 | Zip Code | | | 10g. (| Citizen of V | What Count | try? | _ |
| th with ms 23 must | ner | 108 Hami | ilton Av | | | - I40 | | 20901 | | " N A | | 1 | Stat | | _ |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. | þ | 11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed | | 12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates. | | | If Yes, sp | ecify Cuba | lispanic Origin? (S) an, Mexican, Puert Specify: | oecity Yes or No- o Rican, etc.) | - | | e - America k, White, e B1 | | |
| 2 hour | plet | (Spe | 15. Decedent's | Education grade completed) | | | | ual Occup | ation during most of wo | king | 16b. | Kind of B | usiness Ind | ustry | |
| ithin 7 iene. r than the M | Completed | Elementary/Second 12 year | onday (0-12) ° S | College (1-4 or | ō+) | life. L Ho | oo not u usew: | seretired) ife | | | F | riva | te | | |
| filed wall Hyg | Be c | 17. Father's Name (F | First, Middle, Las | t) | | | | | 18. Mother's Na | me (First, Middle | , Maide | n Surname | e) | | _ |
| uld be I Ment narke natic e | 으 | Major Wa | | | | | | | - | ia Kilb | | | | | |
| and 2 sho lealth and sm 27 is r her traur | | | Davidson | - Daughte | | 108 | Hami: | Lton | Avenue S | | prin | ng, M | D 209 | 01 | |
| Page 1 ament of hant it ite | | | | Removal from State | C | lace of Disp emetery, cre 11 s R | matory of | other plac | | Date une 29, | | | City or Tov ashin | on, State | |
| permit Depart Import any inj once, | | 21. Signature of Fur | neral Service Lice | ensee 120 | | | | | ss of Facility S ing Road | tewart 1 | | | | | |
| | | 23a. Part 1. Enter ti | he disease, or co | mplications that caused | the death | | | | | | | igcon | | Approximate | |
| Physician/ | | Immediate Cause (I disease or conditio | Final | one cause on each line |) | 20 | · 4 | hri | 41 | | | | | Interval Between Onset and Death | |
| Medical Examiner | | resulting in death) | | Due to (or as | | , | | | | | | | | | _ |
| · · | Jer | Sequentially list con if any, leading to im | | b. Due to (or as | a consequ | uence of): | De | mei | Ha. | | | | _ | | _ |
| executed an and rial-transit | Examiner | cause. Enter Under Cause (Disease or i that initiated events | rlying iinjury | 625H | ory | 20 | SAR | evo | · ha. | | | | | | |
| ⊕ E E | cal E | resulting in death) L | _ast | Due to (or as | a consequ | ience of): | | | | | | | | | |
| ificate ig phys as the | Medi | IF FEMALE: | | a | | | | | | | | | | | _ |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu | Physician/Medical | 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown | months? | 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Feta | Ideath 3 | Ectopi | | су | | | 23d. Dat | te of deliver | ry Day Year | |
| that the | by Pl | _ | | contributing to death b | | | underlyin | g cause giv | ven in Part I. | 23e. Did 1 | tobacco | use contr | ibute to the | cause of death? | |
| equires een sig ould b | ted | Reci | north | L bron | Ma | 110 | | | | 1 🗆 | Yes : | 2 🗆 No | 3 Prob | ably 4 Unknow | 'n |
| e law re hasb ge 2 sh | Completed | | | | | | | | | 24a. Was auto perfe | | , E | prior to com leath? | sy findings available apletion of cause of | |
| an: Th tificate tor, pa | Be Co | 25. Was case referre | ed to medical | | | | | 26. Pla | ace of Death (Che | 1 Yes | 2 2 | No 1 | Yes 2 | No | _ |
| hysici his cer Il direc | To B | | No | | | ER/Outpatie | | DOA Othe | er: 4 Nursing H | lome 5 🗌 Resi | idence | 6 🗆 Othe | er (Specify) | | |
| eath. eath. or: After t | Certificate: | 27. Manner of Death 1 Natural 2 Accident 3 Suicide | 5 Pending Investigat 6 Could not | | | 28b. Time o injury | of M | 28c. Injury work 1 \Box | | 28d. Describe | how inju | ary occurre | ed | | |
| ital or Att urs after d ral Direct led in by | | 4 Homicide | determine | | | | reet, facto | ry, office | 5 | 28f. Location (City or Tou | | | er or Rural F | Route Number, | |
| the Hosp in 24 hou the Funer inpleted fil | Medical | (Check 2 | Medical Exa | nysician: To the best of miner: On the basis of e urse Practioner: To the | xamination | and/or inves | stigation, i | n my <mark>opini</mark> c | on, death occurred | at the time, date | and plac | e, and due | to the caus | se(s) and manner stat | ted. |
| P P P | | 29b. Signature and t | title of certifier | per | | | | oc. License | sumber 5456 | 6 | 29d. D | ate signed | (Month, D | ay, Year) | |
| TH | | 30. Name and addre | 1 | completed cause of d | eath (Item | 23a) (Type, | Print) | | | | | mì Ma | | 2-0 - | _ |
| Sta | te | 31. Date filed (Month | n, Day, Year) | GOVIII, G 32. Registra | ar's Signat | ure v | 4100 | HVY | NU # 1-1 | 1, 511/1C | V1 | 7/110 | 100 | 120902 | 3 |
| Registra | ar | IIIN 2 Q | 2012 | Lama W. | Alle | Res | | | | | | | | | |

| 12-05035 Sarah Warren Evar | | pe or Print in E tate of Maryland | | | | | | egible. | | | |
|---|---|--|--------------------------|--------------------------------|-------------------------|--|-------------------------------------|--------------|-----------------------------|--------------------|----------------------------------|
| | 1- For State Registrar | | | ate of L | | | | Reg. No. | 20 | 12 | 223 |
| Physician/ Medical Examiner | 1. Decedent's Name (First, Midd Sarah Warre | | | | | | 2. Date of De Month July 5, 2 | Day | Year | | e of Death |
| | 4a. Facility Name (if not institution 17501 Barnesville Ro | · · | er) | | City, Town, o | or Location of Dea | | 4c. C | County of De | | |
| Funeral | 5. Social Security Number | | Age (In yrs. last bir | | If Under 1 Ye | | rs. 8. Date of E | | ontgomery | | (State or |
| Director | 579-60-2639 | 1M 2_XF 5 | 55 | Yrs. | Months Da | | in. | 6,195 | For | eign Country) | • |
| any | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | | 10d In | side City Limits |
| ▶ | Md. Mont | gomery | | nesvil | | | | | | | Yes 2 X No |
| th the Maryland 23a or 28a-f show notified at ooce al Director | 10e. Street and Number | | | Ţ, | Of. Zip Code | | | 10g. Citizer | n of What Co | ountry? | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at looce. To Be Completed by Funeral Director | 17501 Barnesv: | | | T40 W - | 208 | | | | U.S.A | | |
| r death with , or items 23, .must be no | 1 Never Married 2 M | arried 12. Was Deceder Armed Forces | | | | ispanic Origin? (: in, Mexican, Puer | | 10- | I. Race - Am White, etc. | | an, Black, |
| s after or ural", or niner m | | orced If Yes, Give Year | | | es 2 X No | | | Sp | pecify: | Whi | te |
| 2 hours "natur | 15. Decedent's Education (Spe Elementary/Secondary (0-12) | | | | | ation (Give kind o e. DO NOT use re | | 16b. Kind | d of Busines | s/Industry | |
| 5-0036 ed within 72 hour byggiene. other than "natu the Medical Exan Completed | | 4 | | og Br | eeder | | | Se | lf Emp | ploye | d |
| filed w I Hygie ad othe | 17. Father's Name (First, Middle | <i>'</i> | • | | | 18.Mother's Nam | | | • | | - |
| 2121 Muld be fi Mental I marked c event, | 19a. Informant's Name/Relations | Evans, Jr. | 19 | b. Mailing A | ddress (Stre | RATI et and Number or | Rural Route Nu | | | ite, Zip Co | de) |
| MD d 2 sho lth and lth and numati | Katherine W. 1 | Evans/Mother | | 3125 C | Stree | t, NW., | | ton, | DC 20 | 007 | |
| Ore, es 1 an of Hea If ite | 20a. Method of Disposition 1 Burial 2 Cremation | 3 Removal from S | | of Disposition ory or other | n (Name of ce place) | | Date 2012 | 20c. Loc | cation - City | or Town, S | tate |
| Itim it. Pag utment ortant: y or of | 4 Donation 5 Other Sp. 21. Signature of Funeral Service | I laterage | | | n Crem | | ly 8. | A | 1exan | dria, | Va. |
| Ba perm Depa Imp | Homes | Francisco MOUZ | | 2222 | Wisco | nsin Ave | eVol Fu | Wash | ington | n.DC | 20007 |
| Physician /Medical | 23a. Part I. Enter the disease, or failure. List only one cause | complications that cause on each line. | d the death. Do no | ot enter the | node of dying | , such as cardiac | or respiratory ar | rest, shock, | , or heart | Appro | en Onset and |
| Examiner | Immediate Cause (Final disease or condition resulting in death) | a Liver Cir | | | | | | | | | Death |
| | Sequentially list conditions, | b | | | | | | | | | |
| xaminer | if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated | Due to (or as a cons | sequence of): | | | | | | | | |
| Exar Exar | events resulting in death) Last | Due to (or as a cons | sequence of): | | | | | | | 1 | |
| Box 68760, te death certificate be executed the attending physician and ed for use as the burial - transit hysician/Medical Exa | X UNPENDED | d. AMENDED 23a | ,27,per | me,g9 | 29 7-2 | 7-12 sm | | | | _ | |
| 760, icate by physic the but | IF FEMALE: 23b. Was decedent pregnant in th | 23c. If yes, outco | me of pregnancy | | | | | | ate of delive | ery | |
| x 68 th certification transfer to a sa | past 12 months? | 4 Pregnant a | t time of death 5 | | death 3 (Specify) | Ectopic pregn | ancy | Mo | onth | Day | Year |
| box 68760, the death certificate be executed the attending physician and ched for use as the burial - transparent of the physician/Medical | 1 Yes 2 No 9 ✓ Unk Part II. Other significant condit | 9 OHRIOWII | the hout mot annualities | - in the | | | Loop Bidd | | contribute t | | |
| Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be after death. In Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burnerfification: To Be Completed by Physician/Mee | Taren. Onlor agrinoant conditi | one contributing to dear | an bat not resulting | y in the und | enying cause (| given in Part I. | | s 2 N | | | ✓ Unknown |
| Records, The law requires ficate has been sign, page 2 should be Completed | - | | | | | | 24a. Was | | | | dings available n of cause of |
| Reco | | | | | | | | rmed? | death? | | 2 No |
| ital Fician: certificector, I | 25. Was case referred to medical examiner? | Hospital: | | | | of Death (Check | | | | | |
| of Vi g Physi her this neral dir | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of Inju (Month, Day,) | | utpatient 3 Fime of Injur | | ry at Work? | ng Home 5 | | e 6 🗸 Othe | er: Scene | |
| ion (tending eath. the fur the fur atton | 1 Natural 5 Pend 2 Accident Inves | | Year) | | 1 , | Yes 2 No | | | | | |
| Division or strending supital or Attending hours after death. Neval Director: After filled in by the fune. Certification: | 3 Suicide 6 Could | not be 28e. Place of in | njury - At home, fa | rm, street, fa | actory, office b | ouilding, etc. | 28f. Location (or Town, S | | Number or R | ural Route | Number, City |
| Tospita 4 hours 'uneral | 4 Homicide | ysician: To the best of m | w knowledge des | ith occurred | at the time | ate and place | | | | ut and | |
| Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transis. Medical Certification: To Be Completed by Physician/Medical E) | (Check only | niner: On the basis of exa and manner stated. | in ination and/or in | vestigation, | in my opinion | i, death occurred | at the time, date | and place, | and due to t | neu. he cause(s | s) |
| | 29b. Signature and title of certifie | | - | | 29c. Licens | | | 29d. Date | e signed (Me | onth, Day, | Year) |

DHMH 17 Rev 1/2001 OCME 2006 30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio M.D., Ph. D. Assistant Medical Examiner

State 31. Date filed (Month, Day, Year)
Registrar 111 1 0 2012

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | For State | State of Maryland | | | | | ental Hyg | giene | 012 | 22384 |
|--|------------------|---|---|------------------------------|--|--|--------------|----------------------|----------------------|-----------------|---|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cer | tificate o | Death | | | Reg. No. \subseteq | 012 | |
| Physicia | an/ | Alexander Evashko | | | | | | 2. Date of Dea | Day | Year | 3. Time of Death |
| Medi Examir | | 4a. Facility Name (if not institution, give str | | | 4b. City, Town | or Location | of Death | June 2 | | ty of Death | 2:50a.m. ^M |
| Exami | ici | Charlotte Hall Vete | , | | Charlo | | | | | Mary's | , |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. la | st birthday) | If Under 1 Yea | ar If Unde | er 24 Hrs. | 8. Date of Birth | h | 9. Birthpl | ace (State or Foreign |
| Director | | 720-10-9601 | M 2 □ F 92 | Yrs. | Months Day | s Hours | Min. | 07/24/ | 1919 | Countr Massa | y) achusetts |
| nd now | ٦ | Usual Residence of Decedent 10a. State 10b. County | 10c City | , Town or Loc | ation | | | | | 10 | d. Inside City Limits |
| arylar a-fsl | 읂 | | | | | | | | | 10 | 1 🗆 Yes 2 🛣 No |
| or 28 | Funeral Director | Maryland St. Mary 10e. Street and Number | s Chai | rlotte | 10f. Zip Code | 9 | | | 10g. Citizen of | What Count | |
| with 1 23a ust b | eral | 29449 Charlotte Ha | 11 Road | | 20622 | | | | United | | |
| leath items er m | 틢 | | 2. Was Decedent Ever in U.S Armed Forces? | . 13. W | Vas Decedent of Yes, specify Cu | Hispanic O | rigin? (Spec | ify Yes or No- | 14. Ra | ice - America | n Indian, |
| ifter of in a | Š | 1 Never Married 2 Married | 1 XYes 2 No | | Yes 2X | | | ilcan, etc.) | | ack, White, et | c. |
| tural", o | Completed | 3 Midowed 4 □ Divorced | Year or Dates. | | | | у. | | Specif | wnit | |
| 72 hc | ם | 15. Decedent's Educ (Specify only highest grade | completed) | (Give k | ent's Usual Occ ind of work don NOT use retire | e durina mo | st of workin | g | 16b. Kind of I | Business Indu | ustry |
| within 7 giene. | ខ | Elementary/Seconday (0-12) | College (1-4 or 5+) | | and Die | | <u>_</u> | | Machin | erv | |
| and be filed vental Hyg | Be | 17. Father's Name (First, Middle, Last) | | 1001 | Ind Dic | | | (First, Middle, N | | | |
| d be d be d Vients arked | P | Efrem Evashko | | | | Mar | y Gre | wsky | | | |
| shoul and is m | | 19a. Informant's Name/Relationship (Type | , | | g Address (Stre | | | | | | |
| and 2 tealth | | Linda Brown/Caregi | | | | Road, | Apt. | 84D, Le | | | , MD20653 |
| perfull IOTe, INICITY ALL IN-UDOO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minipury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1 | moval from State | metery, crem | sition (Name of atory or other p | | | ate | 20c. Location | • | |
| Dallinor Department of mportant: If it any injury or o | | 4 Donation 5 Other (Specify) | Bri | | ld-Echo | | | /2012 | | | |
| Department of the permit of th | | 21. Si ma ure TFuneral Service Dicense | stidist | | Name and Add | | | | | | |
| | | Michele Brinsfie 23a. Part 1. Enter the disease, or complic | | | the mode of d | | | | | | Approximate |
| Physician/ | | shock, or heart failure. List only one a Immediate Cause (Final | cause on each line. | | s DE | | | | | | nterval Between |
| Medical | | disease or condition resulting in death) | Due to (or as a conseque | | 3 /20 | mer | 1 | | | - 3 | grans |
| Examiner | L | Sequentially list conditions 5 | | | | | | | | | |
| n # | ine | if any, leading to immediate cause. Enter Underlying | Due to (or as a conseque | ence of): | | | | | | | |
| ecuter and trans | Examiner | Cause (Disease or linjury that initiated events c. resulting in death) Last | Due to (or as a conseque | 2000 | | | | _ | | | |
| te be executed hysician and he burial-transit | dical E | resulting in death) Last | Due to for as a conseque | siice oi). | | | | | | | |
| Attending Physician: The law requires that the death certificate be executed at death. Attending Physician: The law requires that the death certificate be executed at death. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | edic | d. | | | | | | | | | |
| eath certificate attending phy | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | . If yes, outcome of pregnan | | | | | | 23d D | ate of deliver | , |
| e atte | icia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 Live Birth 2 Fetal 4 Pregnant at time of de | | Other (specify) | incy | | | | | yay Year |
| that the dec | hys | 9 Unknown | 9 Unknown | | | | | | | | |
| es that igned be def | by | Part II, Other significant conditions contr | | Iting in the un | derlying cause | given in Parl | t I. | | | | cause of death? |
| require been si should I | ted | HYPORTERISA | | 0 | | | | 1 🗆 Y | es 2 No | 3 Proba | bly 4d Unknown |
| law re has be e 2 sh | Completed | DEGENERATI | VE JUINT | DISE | MJE | | | 24a. Was a autops | sy | prior to com | y findings available pletion of cause of |
| : The la | | FAILURE TO | THRIVE | - | | | | 1 🗆 Yes | med? 2 Mo | death? 1 Yes 2 | □ No |
| ician: The certificate rector, pag | m | 25. Was case referred to medical examiner? 1 Yes 2 No | spital: | | | Place of Deather: | | | | | |
| ding Physician: h. After this certific | 2 | 27. Manner of Death | 1 Inpatient 2 E 28a. Date of injury | R/Outpatient 28b. Time of | 3 ☐ DOA 28c. Inj | 4 | | e 5 Reside | | | |
| nding ath. : Afte e fune | cate | 1 | (Month, Day, Year) | injury | wo | ork? Yes 2 | _ | d. Describe no | w injury occur | ieu | |
| r Attendi er death. rector: A by the fu | Certificate | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hom | ne, farm, stree | et, factory, office | 9 | 28 | Bf. Location (St. | | er or Rural R | oute Number, |
| talor rs affe al Dir | Ö | | building, etc. (Specify) | | | | | City or Town | , State) | | |
| To the Hospital or Attendi within 24 hours after death To the Funeral Director. A completed filled in by the fi | Medical | 29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner | an: To the best of my knowle On the basis of examination | dge, death oc | cured at the tin | ne, date and | place, and | due to the caus | se(s) and mann | ner as stated. | e(s) and manner stated |
| thin 2 the I | Me | only one) 3 Certifying Nurse F | ractioner: To the best of my | knowledge, de | eath occurred at | the time, dat | e and place, | and due to the | cause(s) and m | anner as state | ed. |
| 5 ≥ 6 ⊗ | | 230. Signature and the discontinuer | 460 | | LLAN | se number | 28 m | | 9d. Date signe | d (Month, Da | |
| | | 30. Name and address of person who com | pleto cause of death (terri | 220) (Time - Ti | int) | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 1 | 0 0 | Jeric | 24 | 20/2 |
| Deme | | 29449 Char | lotte Ha | I P | | - ha | 1 | HO 11 | 291 | tor, | 720622 |
| Stat | е | 31. Date filed (Month, 1991) 2 5 201 | 32. egistrar's Signatu | 198 / | 4 | -110 | 01.16 | VIC IT | uu) I | 1117 | - 20024 |
| Registra | ar | 2011 & 3 201 | 4 france | D. 160 | ale | | | | | | |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 June 26, Ferguson Arthur Merle 3:11 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19 Walker Avenue Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 214-28-0778 1 XM 2 □ F 81 Yrs Dec. 26, 1930 Maryland Usual Residence of Decede or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Walker Avenue 20877 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Career Fire Fighter Fire Department Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Arthur Cralle Ferguson Dorothy Μ. Magruder and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ann S. Ferguson - Wife 19 Walker Avenue, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Forest Oak Cemetery | 6/29/2012 Gaithersburg, Maryland Signature of Funeral Service License 22. Name and Address of Facility iams P.A., Funeral Homo Molesworth-Williams P.A., Funeral Homo 26401 Ridge Road, Damascus, Maryland Funeral Home ove it 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of the rectum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy s certificate has director, page 2 perform rmed? 2 X No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D37142 June 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 + IVA

State Registrar Coleman, M.D.

31. Date filed (Month, Day Ye

DHMH 17 Rev 06-2011

Rockville, Maryland

1355 Piccard Drive,

32. Recistrar's Signature

recar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death FISHER Physician/ Month C MAI 0415 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Hours 79 Director 215-32-0284 1 XM 2 □ F Aug. 31,1932 Delaware show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be r Funeral 702 Hillcrest Drive 21409 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Korean Black, White, etc. <u>8</u> 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: White If Yes, Give War 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Master Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Fisher Edna Dodd of Health and Mer of Health and Mer fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Fisher / Wife 702 Hillcrest Drive Annapolis, MD 21409 other i Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō Department of Important: If it any injury or or 1 XBurial 2 Cremation 3 Removal from State June 19, Lakemont Davidsonville, MD 5 Other (Specify) 2012 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, gnature of Fun ral Service Live Severna Park Funeral Home Severna Park, MD 21146 P.A. art 1. E ter the disease, or shock, o/heart failure. List o complications that caused the death. Do not enter the mode of dying, by one cause on each line. terval Between Ir mediate vause (Final uisease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialbeen signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director; After this certificate has autopsy performed 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? 2 🗀 No 2 Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 9b Signature and title of o X 5

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 3:18 P M Julio F. Gonzalez June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Month, Day, Year) 2/24/1944 Days 1 X M 2 D F 580-90-4815 Director 68 Puerto Rico Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norfified ** once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗵 No Ceci1 North East 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 37 Bay View Woods Loop 21901 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force 1 X Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican If Yes, Give 3 Divorced Spanish Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Material Handler Rubber Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mariano Gonzalez Augustina Figueroa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Cintron - daughter Bay View Woods Loop, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6/29/2012 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) R.T.Foard Funeral Home. PA Rising Sun, MD 21. Signature of Funeral Service Censes 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or iti resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of if a y leading to immedicause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl performe 1 ☐ Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this
if filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my capitoe, death an armount of the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D0062190 28

State Registrar

GUSTINE 31. Date filed (Month, 32. Registrar's Signature

33

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAHNAWAZ

SUITEA, CHESAPEAKECITY, MD21915

TERMAN HWY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 2012 ear Nei1 Bennett Gordon June 25. 6:15 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 148-24-9882 Director 79 1 🛛 M 2 🗆 F Yrs 09/30/1932 Connecticut 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD St. Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43918 Lanedon Drive 20650 United States permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Equipment Specialist Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Η. Leo Gordon Christel D. Erickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly 011om 43918 Lanedon Drive, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Brinsfield-Echols 06/28/2012 4 Donation 5 Other (Specify) Charlotte Hall 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. 22. Name and Address of Facility Danielle Ward NO1403 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. angiosarzona of Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardio 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner

28a-f show

23a or 5

Baltimore, Maryland 21215-0036

page 2

P.O. Box 68760 the s been signed by the should be detach Division of Vital Records, has this certificate funeral director,

Sordon, Nei

attending physician and for use as the burial-trai Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Malignant ethicion 1 ☐ Yes 2 ☐ No Yes 2 W No • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 No 1 Impatient 2 I ER/Outpatient 3 DQA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRY'S HOPPITAL, LEGNARPTOWN MD.

29b. Signature and title of certifier

INTERMIST

Social guMD

Registrar

DE 62133

29d. Date signed (Month, Day, Year)

6/28/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARGARET 2012 6:40 AM GARDNER June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 198-22-6803 Months Hours Director 1 □ M 2 🏝 F 90 March 13, 1922 Scotland 5 2 2 2 or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at **Funeral Director** 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 5380 Stone Road 21703 United States of America 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other trans any injury or other traumatic event an once. 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Dodds Lizzie Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Deering / Daughter 5380 Stone Road, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombment Mount Olivet Cemetery June 30, 2012 Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Bastord P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death NSTEMI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 s certificate ha performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No ျှ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year

State Registrar

5

DHMH 17 Rev 06-2011

400 WEST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

D0063498

S'EVENTH STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TIMOTHY WAYNE HARNE July 2012 9:39p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 1 ▼M 2 □ F Min. 52 Director 214-84-1848 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Frederick Sabillasville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14339 Brown Road 21780 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ۾ 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. should be filed within 72 hours aft and Mental Hygiene. 'Is marked other than "natural", Specify: White Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Repairman Furniture Sales æ 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Rudolph Vaungene Harne Anna Lois Hartle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Harne/wife 14339 Brown Road, Sabillasville, MD 21780 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garfield U. MethodistJuly 9,2012 Garfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 504 Main Street Signature of Funeral Service Ticen 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Fiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot in heart failure. List only one cause on each line. shoo r heart failu Immediat Cause (Final Onset and Death Icoholic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha perform 1 Yes 2 No 2 No Yes Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) director 6 Other Specify Other: 4 Nursing Home 5 Residence 1 Yes 2 🗆 🕦 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 5 Pending 2 🗆 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat d title of certifier 7-6-2012 MD D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Hernen Shuh

31. Date filed (Month, Day, Year)

Thomas

32. Registrar's Signature

45 C

Frederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Henderson Month Michael Year P: SDPM 06 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 2761 Gingerview Lane Annapolis Anne Arundel 5. Social Security Number . Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 199-36-0418 63 Months Hours Director 1 XM 2 D F 1/6/1949 IL Usual Residence of Deced 28a-f show 10a. State aţ 10b. County 10c. City, Town or Location Director 10d. Inside City Limits be notified MD Anne Arundel Annapolis 1 Yes 2XXNo 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? Funeral 23a traumatic event, the Medical Examiner must 21401 2761 Gingerview Lane IISA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black White etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. White "natural", If Yes, Give Specify. Completed 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Sales Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Newman Mary Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Cedar Falls CT.SW Lilburn, GA 30047 <u>Melissa Waller</u> daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 4 ☐ Dor ation 5 ☐ Other (Specify) Atlantic 6/28/2012 Crematory Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 23a. a /1. Enter the diverse suck, or heart face. List only one cause on each line.

If mediate Cause (Fire) Approximate Interval Between MOSIS Onset and Death Physician iver sise se or condition repulting in death) CITT Medical Due to (or as a consequence of) **Examiner** sease quertially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No ped 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ypinat reni 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No Yes 2 4No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural injury work?
1 ☐ Yes 2 ☐ No s after death. Accident Suicide Investigation M filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68693 W 06 2

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day,

detense

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Linthicum Tate House Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 579-72-6844 Director 1 M 2 X F 86 Yrs 1/6/1926 Jamaica Usual Residence of Decedent or than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a, State filed within 72 hours after death with the Maryland 10c. Cify, Town or Location 10d. Inside City Limits Director Anne Arundel Hanover 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2109 Piney Branch Circle 21076 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Yes XX No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 xxlo Specify: B1ack Specify: 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Importent: If item 27 is marked other till eny injury or other traumatic event, the 200ce. Hospital Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Prince Albert Lewis Alice Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Piney Branch Circle Hanover, MD 21076 Patricia Alexander daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial ※X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/24/2012 Glen Burnie, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 7 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of): Hospitel or Attending Physiclen: The law requires that the death certificate be executed sicien and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physicien page 2 should be detached for use as the burial Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Pregnant at time of death Month Day 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of property howledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) and fittle of certifia -HME31. Date filed (Month, Day, Year) State JUN 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Hoffman Katherine 11: 20 AM 2012 ILA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arnold FutureCare Chesapeake Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 232-26-3561 91 Director 1 □ M 2 🔀 F Nov. 10,1920 West Virginia or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be n Funeral 21146 USA 41 W. McKinsey Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 🛛 No Black, White, etc. 1 Never Married 2 Married þ Yes Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Agnes Butker William Steven Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Bay Drive Stevensville, MD 21666 Patricia Sullivan/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 14, 2012 cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) Si ture of F neral Servic Li Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or yeart failure. List only one cause on each line. Im ediate Cause (Final Onset and Death Physician/ 119 carcinomo disease or indition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ for Month Day Year Pregnant at time of death 9 Unknown the 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown carinon 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 유 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No s after death.

I Director; Aff
ed in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral D completely filled i Medical 🏿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57531 une 13 2012 M 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millersville nD 8601 Veterans 21108 mohit

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN 15 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Fime of Death 2. Date of Death Physician/ Month Hal 1841 AM. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PONINSULA RegiONAL MEDICAL HICOMICA Centa SALISBURG If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Min. (Month, Day, Year) Days 220-26-9098 Director 1 □ M 2 🗷 F 0 Maryland r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Somerse Princess Anne 1 🗆 Yes 2 🔼 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32700 Boston Rd. 2185 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ۵ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕅 No Specify: 3 № Widowed 4 Divorced Specify: Black Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade 17. Father's Name (First, Middle, Last) Lanning Taci 18. Mother's Name (First, Middle, Maiden Surname) SE Charles Cannon Borne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Son Kirkland Hall Sr. 30011 Saint James Way Princess Anne, MD, 21853 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -30-12 Oaksville, MD mark's 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward 30639 Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ ardi emujo ì disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease on injury that initiated events Examine Due Disea Hospital or Attending Physician: The law requires that the death certificate be executed use as the burlal-tran resulting in death) Last Due to (or as a consequence within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burlal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Fiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying phyrics Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D71972 30. Name and address of per who completed cause of death (Item 23a) (Type, Print) Sha filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6/22/2012 Day 4:22 P Rosalee Virginia Quillen James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 103 Burley St. Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2 X F Hours 82 7/11/1928 Director 220-26-3167 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Berlin MD Worcester 1[™] Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA 103 Burley St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Marylanٰd 21215-0036 1 Yes XX No Specify: Specify: white 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beauty shop Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beulah Lee Trader Calvin E. Quillen, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5886 Quaker Neck Rd. Chestertown, MD 21620 Joyce J. James (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔁 Burial 2 🗆 Cremation 3 🗆 Removal from State Buckingham Cemetery |6/30/2012 Berlin, MD 4 Donation 5 Other (Specify) Signatur Service Lice 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications to hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying
Cause (Disease or linjury Due to for as a consequence of burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

24 hours after death.

Funeral Director. After this certificate has been signed by the attending physicis be Funeral in by the funeral director, page 2 should be detached for use as the bruneled filled in by the funeral director, page 2 should be detached for use as the bruneled. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Math 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

BAIR

State Registrar Name and address of person who completed cause of death (Item 23a) (Type,

(Month, Day, Year)

JUN 28

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June T: 45 pm Freida E. Jaley 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs, last birthday) 349-90-2704 1 🗆 M 2 🗴 F 45 09/06/1966 Sri Lanka 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 □ No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 20817 7415 Bradley Boulevard Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 X Married Specify: Asian Indian 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Government Contracting 5+ Chief Financial Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pricha Pillai Katpagam Dixon Smith Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7415 Bradley Blvd., Bethesda, Maryland 20817 Mohan K. Jaley - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 06/18/2012 Adelphi, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Breast Cancer Year disease or condition

Physician/ Medical Examiner Examine

Physician/

Medical

Examiner

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.

Director

Funeral

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Completed

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

completely filled in by the funeral within 24 hours after deat.

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

| | resulting in doubly | Due to (or as a consequence of): | | | |
|--------------------------------|---|---|---------------------------------------|---|--|
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a consequence of). | | | Ď. |
| | that initiated events resulting in death) Last | C. Due to (or as a consequence of): | | | |
| b | | | | 1 | |
| Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 | pic pregnancy rr (specify) | | 23d. Date of delivery Month Day Year |
| oy Ph | Part II. Other significant conditions co | ontributing to death but not resulting in the underly | ing cause given in Part I. | | use contribute to the cause of death? |
| ₽. | | | | 1 Yes | 2 💢 No 3 □ Probably 4 □ Unknown |
| omplete | | | | 24a. Was an autopsy performed? | |
| O | 25. Was case referred to medical | | 26. Place of Death (Check | | |
| To Be | outaminos? | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ | | | 6 X Other (Specify) Hospice |
| | 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation | | work? | 8d. Describe how inju | ury occurred |
| Medical Certificate: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify) | ctory, office 2 | Ref. Location (Street a City or Town, Star | and Number or Rural Route Number, te) |
| ledica | (Check 2 Medical Exami | sician: To the best of my knowledge, death occurniner: On the basis of examination and/or investigation se Practitioner: To the best of my knowledge, death | n. in my opinion, death occurred at 1 | the time, date and plac | ce, and due to the cause(s) and manner stated. |
| 2 | 29b, Signature and title of certifier | | 29c. License number | | Date signed (Month, Day, Year) |

D0060634

June 14, 2012

DHMH 17 Rev 06-2011

Registrar

10

Bindu Joseph, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 19 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ LaRhonda Caroline Johnson 2012 Medical Tune 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Medical Center Fort Washington Georges Prince Year If Under 24 Hrs. Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 🛣 (Month, Day, Year) Yrs. 577-90-7671 Director 43 Feb. 2.1969 Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 No MD PG Fort Washington 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? Funeral 23a Stonesboro Road 3707 20744 United States ral", or items ? death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married permit, Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Black "natural", 3 Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical i 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contract Specialist Fed. Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marion White Betty Blakely 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stonesboro Road Washington, MD. Paul Johnson/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Harmony Mem. Park 6/23/12 Landover MD
22. Name and Address of Facility Hodges & Edwards F.H. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myscardy disease or condition resulting in death) Medical (or as a consequence of): **Examiner** Sequentially list conditions, # a.y, leading to Immediat cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (dras a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Other (specify) Pregnant at time of death the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy this certificate 2 No Yes 1 Yes 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After iniury 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00065385 Name and address of person who completed cause of death (Item 23a) (Type, Print) ivingston Pd., Ft. Washington, HD 31. Date filed (Month, Day, Year) State 2 6 2012 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| | | 1 _ State | of Marylan | | ertment of Hertificate of L | | Mental Hy | - | | 2 2239 | 8 |
|--|---------------------------|--|--|---------------------|---|-------------------------|-------------------|---------|--------------------|---|----------|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | | Timeate of E | | 2. Date of D | Reg. N | 10, | 3. Time of Death | |
| Physicia | | Rodney Kitchings | | | | | Month | | 2012 | | |
| /Medic Examin | | 4a. Facility Name (If not institution, give street and | number) | | 4b. City, Town, or | Location of Deat | June_ | | c. County of Dea | | \dashv |
| Examin | EI | Bel Pre Health & Reha | | าท | Silver | | | | Montgo | merv | |
| Funeral | | Social Security Number 6. Sex | 7. Age (In yrs. | | If Under 1 Year | | 8. Date of Bi | rth | | rthplace (State or Foreign ountry) | n |
| Director | | 579-44-3801 1™ 2□ F | 75 | Yrs. | Months Days | Hours Will. | | | | hington, DC | |
| pu 🛊 | | Usual Residence of Decedent 10a. State 10b. County | 10c Cit | y, Town or L | ocation | | | | | 10d. Inside City Limits | |
| laryla sho | ō | | | | | | | | | 1 to Yes 2 □ No | |
| the N | Director | Maryland Montgomery 10e. Street and Number | Si | ilver | Spring 10f. Zip Code | | | 10a. C | Citizen of What Co | ountry? | \dashv |
| with Ba or | ٥ | 2601 Bel Pre Road | | | 20906 | | | Ü | nited St | , | |
| ns 2 | Funeral | | ecedent Ever in U. Forces? | S. 13. | . Was Decedent of Hi If Yes, specify Cuba | spanic Origin? (5 | Specify Yes or N | | 14. Race - Am | erican Indian, | \dashv |
| or iter | Ē | 1 ☐ Never Married 2 ☐ Married 1 ☑ Ye | s 2 □ No | | | | to Rican, etc.) | | Black, Whit | | - |
| 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, Its Medical Eventines in a must be mailfud at | d b | 3 ☐ Widowed 4 🙀 Divorced If Yes, Year of | Dates: | | 1 □Yes 2 🙀 No | Specify: | | | Specify: | Black | |
| 72 ho | Completed | 15. Decedent's Education (Specify only highest grade complete | d) | (Give | edent's Usual Occupa e kind of work done o | during most of wo | rking | 16b. | Kind of Business | s/Industry | |
| vithin | mp | | (1-4or 5+) | lite. | DO NOT use retired |) | | | | | |
| iled v Hygie ther t | ပ္သ | 12 years | | | Clerk | 18. Mother's Nar | ne (First, Middle | | Governme: | nt | \dashv |
| d be fantal ed o | Be | 17. Father 3 Marile (Finst, Missio, East) | | | unk. | Geraldi | | | ŕ | | |
| mark | ျှ | 19a. Informant's Name/Relationship (Type. Print) | | 19b. Mail | ling Address (Street a | | | | | Zip Code) | \dashv |
| nd 2 s ulth ar 27 ls r trau | | Cheryl Wheeler - Siste: | r | | Blair Roa | | | | | | |
| t Hear f Hear f Hear other | | 20a. Method of Disposition | 20b. P | Place of Disp | position (Name of ematory or other place | 0) | Date | 20c. | Location - City or | r Town, State | \neg |
| Page: nent o nt: If | | 1 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify) | m State Qua | antico | Nat'l Cer | nt June | 27, 20 | 12 | Trian | gle, VA | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examination in the modified at once. | 1 | 21. Signature of Funeral Service Licensee | | 2 | 22. Name and Addres | s of Facility S | tewart | Fune | ral Hom | e, Inc. | \neg |
| permi Depa Impo any Ir | | John T. Stewart | | 4 | 001 Benni | ng Road, | NE Was | hing | ton, DC | 20019 | |
| | | 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of | t caused the deatl | h. Do not er | - | _ | | 1 | | Approximate Interval Between | |
| Physician | | Immediate Cause (Final disease or condition | ATRI | XL | FIBR | ILLA | TION | 1 | | Onset and Death | - |
| /Medical | | resulting in death) | to (or as a consequ | uence of): | | | | | | | \neg |
| Examiner | | Sequentially list conditions, b. | | | | | | | | | _ |
| ed sit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | to (or as a consequ | uence of): | | | | | | | |
| cate be executed physician and the burial-transit | хап | that initiated events C. | to (or as a consequ | nence of). | | | | | | | \dashv |
| be e sician | | | (** | | | | | | | | |
| | edical | d | | | | | | | | | |
| eath certific attending p | Ž | IF FEMALE: 23c. If yes, | outcome of pregna | ancy | | | | | 23d. Date of de | elivery | |
| death e atte d for | icia | in the past 12 months? | re birth 2 ☐ Feta egnant at time of c | | ☐ Ectopic pregnancy ☐ Other (specify) | <u> </u> | | | Month | Day Year | |
| ires that the de signed by the a be detached t | Completed by Physician/Me | 9 Unknown 9 Ur | iknown | | | | | | | | - |
| es the | by P | Part II. Other significant conditions contributing to | death but not resi | ulting in the | underlying cause give | en in Part I. | | | | to the cause of death? | |
| w require been si should b | ed | TYPE | KIEN | 15101 | ~ | | 1 🗆 | Yes | 2 No 3 P | Probably 4 Onknown | 1 |
| law r | ple | | | | | | 24a. Was | | 24b. Were a | utopsy findings available completion of cause of | Э |
| The sate h | 201 | | | | | | perl 1 □ Yes | ormed? | death? | s 2 No | |
| sician: The law s certificate has t irector, page 2 sl | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of De | | | | | \Box |
| Physl this c | P | | | ER/Outpatie | | 4 La Nursing I | T | | 6 ☐ Other (Spe | ecify) | 4 |
| Jing I | ion | 1 Natural 5 Pending (M | te of Injury onth, Day, Year) | 28b. Time of Injury | Work | yat (? Yes 2 □ No | 28d. Describe | now inj | ury occurred | | |
| death death stor: / the | icat | 2 Accident investigation 3 Suicide 6 Could not be | oce of Injury - At he | ome farm st | treet, factory, office | res Z 🗆 NO | 28f Location | /Street | and Number or F | Rural Route Number, | |
| lor A after Direc | Certification: To | 4 Homicide determined bu | ilding, etc. (Specif | y) | tioot, lactory, office | | City or To | | | iarar rioute rumbor, | |
| To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical C | 29a. Certifier (Check only one) 1 Certifying Physiclan: To the and m | | | | | | | | | |
| To the within compl | Me | 29b. Signature and title of certifier | - M.1 |). | 29c. License | e number 5731 | 3 | 29d. [| Date signed (Mo) | ith, Day, Year) 22 12 | |
| 9 | | 30. Name and address of person who completed ca | ause of death (Iten | n 23a) (Type | hersal | let, | Trive | J F | elliatt | -cety 21. | 4 |
| Stat | te | 31. Date filed (Month, Day, Year) 32 | . Registrar's Signa | ture | <i>,</i> | | | | | | T |
| Registra | | JUNE V CUIZ Chara | + P. A | - | | | | | | | |
| HMH 17 Day 1/20 | 01 | | - | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Amend #19B per 12-04420 AA O Robert L. King | b. | Health Please Ty ot lo 1-For State | pe or Print i tate of Maryl | and / D | k Indelibl epartmen <i>Certificate</i> | t of H | ealth a | re All nd Me | Copie ental Hy | es Are L ygiene | .egible | | 2 2239 |
|---|-------------------|---|---|---------------|---|------------|--------------------------------|-------------------------|---------------------------|---------------------------------|---------------------------|--------------------------------|--|
| Physicia | | 1. Decedent's Name (First, Mid | | | | | | | | 2. Date of D Month | eath Day | Year | 3. Time of Death 0552 hrs |
| Medical Exami | ner | Robert L. K.: 4a. Facility Name (if not institut | _ | umber) | | 4b. (| City, Town, o | or Location | on of Death | June 12 | | . County of Deatl | |
| - | | Baltimore Washingto | | | | G | len Burn | ie | | | Δ | nne Arundel | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In | yrs, last birthda | _ | Under 1 Ye | ear If Ur | | - | • | DD/YYYY) 9. Bir Foreiç | gn |
| Director | | 240-68-6024 | 1 M 2 F | | 67 | Yrs. | VIOTITIS DA | 193 | ura jviiri. | Sept | 25 | 1944 % | ontry)Carolina |
| any. | | Usual Residence of Decedent 10a. State 10b. County | , | 10c | . City, Town or L | ocation | | | | | | | 10d. Inside City Limits |
| * . | <u>-</u> | Maryland Anne | e Arunde | 1 | Glen E | Burn | ie | | | | | | 1 Yes 2 No |
| Maryla 28a-f d at or | Director | 10e. Street and Number | | | | 10 | f. Zip Code | | | | 10g. Citi: | zen of What Cou | ntry? |
| ith the Maryland 23a or 28a-f show motified at once. | | 7847 America | | | | | | 060 | | | ļ | USA | |
| ath wi | Funeral | 11. Marital Status 1 Never Married 2 X | 12. Was De Married Armed F | orces? | | | | | | ecify Yes or Rican, etc.) | No- | 14. Race - Amer White, etc. | ican Indian, Black, |
| fter de | | | 1 Yes vorced If Yes, Give Ye | 2 <u>X</u> | | Ye | s 2[X] N | lo speci | ify: | | | Specify: B1 | ack |
| ours a | ed by | 15. Decedent's Education (Sp | | | | | Jsual Dccup of working lif | | | | 16b. F | Kind of Business/ | Industry |
| 36 in 72 h | plet | Elementary/Secondary (0-12 $12 \mathrm{th}$ |) College (| (1-4 or 5+) | | | ociat | | | / | \ \ | Valmart | |
| -00; d with ygiene other t | Completed | 17. Father's Name (First, Middle | - | | | 7155 | ocia | | ner's Name | (First, Middle | | | |
| Baltimore, MD 21215-0036 Exermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f about yor other traumatic event, the Medical Examiner must be notified at once. | Be | Thomas W. Ki | ing | | | | | E1 | dora | Jord | an | | |
| D 21 should and Mer | 오 | 19a. Informant's Name/Relation | | | | | | | | | | | Zip Code)21060 |
| Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is in injury or other traumatic | -1 | Blondell Kin 20a. Method of Disposition | ng(Wife) | - 1 | /84 20b@P¶aqe_qn∫Bj | A / A | Merlo (Name of c | cana emetery, | T | CIE A | 20c. I | Location - City or | Bunie, Mo Town, State |
| nore | | 1 X Burial 2 Crematic | | | Memori | or other p | olace) | | 6- | 19-12 | Du | irham, | N.C. |
| altin mit. P. partmer portan | - 4 | 4 Donation 5 Other 5 21. Signature of Funeral Service | | | | 227Name | and Addres | နှန့် Faci | l ilitySon | s Mor | tuar | ry, P.A | |
| in in Per De Co | 2 | Lavy B. A | eese | | | 192 | 2 For | rest | Dr. | Anna | poli | s, Md. | 21401_ |
| Physician /Medical | | 23a. Part I. En or the disease, failure. List only one caus | e on each line. | | | | | g, such as | s cardiac or | r respiratory a | arrest, sho | ck, or heart | Approximate Interval Between Onset and Death |
| Examiner | | Immediate Cause (Final diseas or condition resulting in death) | | | | Diseas | e | | | | | | Deau |
| | | Sequentially list conditions, | b | | | | | | | | | | |
| | miner | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as | a conseque | nce of): | | | | | | | | |
| sit si | xan | (Disease or injury that initiated events resulting in death) Last | Due to (or as | a conseque | nce of): | | | | | | | | |
| executed an and al - transi | cal | UNPENDED | dAMENDED | | | | | | | | | | |
| P. C. 6 | Physician/Medical | IF FEMALE: | 23c. If yes, | outcome of | pregnancy | | | | | | 230 | f. Date of delivery | / |
| Division of Vital Records, P.O. Box 68760, rat or Atranding Physician: The law requires that the death certificate be an Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burn | ian/ | 23b. Was decedent pregnant in past 12 months? | the 1 Live | | 2 | Fetal d | | Ecto | pic pregna | ncy | | Month [| Day Year |
| 30x death c re atten I for us | ysic | 1 Yes 2 No 9 Ur | nknown g Unkr | | or death 5 | Other | (Specify) | | | | | | |
| b.O. B that the d | | Part II. Other significant cond | tions contributing | to death but | not resulting in | the unde | rlying cause | given in | Part I. | | _ | | the cause of death? |
| S, P, Lires th | ed by | Kidney Disease | | | | | | | | | | | pably 4 🗹 Unknown |
| Vital Records, P.O. ysician: The law requires that th his certificate has been signed by director, page 2 should be detach | Completed | | | | | | | | | | as an topsy formed? | | topsy findings available ompletion of cause of |
| Rec The la icate h | EoS | | | | | | | | | 1 Yes | 5 2 √ No | | s 2 No |
| of Vital Recoing Physician: The law After this certificate has uneral director, page 2.s. | æ | 25. Was case referred to medic examiner? | 11 | Innatient | 2 🗸 ER/Outpa | tient 3 | - | | th (Check o | only one) g Home 5 | Reside | nce 6 Other | , |
| of V g Phys fter thi | <u>ان</u> | 1 Yes 2 No 27. Manner of Death | 28a. Date | of Injury | 28b. Time | | | ury at Wo | | 28d. Describ | | | |
| ion (tendin eath. | ation | | iding estigation | n, Day, rear) | | | 1 | Yes 2 | ☐ No | | | | |
| ivisi or At after d Direct in by | Certification: | 3 Suicide 6 Cou | ild not be 28e. Pla | | - At home, farm, | street, fa | ctory, office | building, | etc. | 28f. Location or Town | | nd Number or Ru | ral Route Number, City |
| Division of To the Hospital or Attending Phywifin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral | | 4 Homicide | ermined (Specify | | 1-1 1 | | -446-44 | data and | | t- th | | J | |
| the H the R the Fu | Medical | (Check only Continying | Physician: To the be aminer:On the basis | of examinat | owledge, death o tion and/or inves | tigation, | at the time, o in my opinio | oate and p on, death | piace, and occurred at | due to the ca t the time, da | iuse(s) and te and pla | ce, and due to the | ed. e cause(s) |
| To vit | Me | 29b. Signature and title of certifi | and manner er | stated. | | _ ^ | 29c. Licen | se numbe | ər | | 29d. [| Date signed (Mor | nth, Day, Year) |
| | | MM | | | | M) | 0.0 | .M.E. | | | June | ∋ 13, 2012 | |
| 31 | | 30 Name and address of perso | | | | 00.14/ | Raltimore | Strac | t Baltim | ore, MD 2 | 1222 | | |
| ω | ate | Russell Alexander Mi | | egistrans Si | | JU VV. | Daimilofe | - Juee | i, Daillin | OIC, IVID Z | . 1223 | | |
| Regist | rar | 31. Date filed (Month, Day Year) | 2012 | we | 1. 6 | erla | _ | | 0 | CME | | | |
| DHMH 17 Rev 1/20 OCME 2006 | 001 | | | | ORIGI | NAL | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | - | For AMEND#1, 3 per PHY State of Maryland / Department of State of Maryland / Department / | artment of Health and Natificate of Death | Mental Hygien | |
|--------------------------------|--|-------------------|--|---|---|--|
| H | Physicia | n/ | 1. Decedent's Name (First, Middle, Last) ELIZABETH—H. LASSITER | | 2. Date of Death Month 6/25/ | 3, Time of Death |
| | Medic Examin | | 4a. Facility Name (if not institution, give street and number) 9003 CANBERRA DRIVE | 4b. City, Town, or Location of Death CLINTON | | 4c. County of Death 8:45AM PRINCE GEORGES |
| | Funeral Director | | 5. Social Security Number 577-40-6083 6. Sex 1 □ M 2X F 81 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year 5/9/1931 | 9. Birthplace (State or Foreign Country) SALISBURY NC |
| | ıryland 1-f show ied at | Director | Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE GEORGES CLINTON | cation | | 10d. Inside City Limits 1 ☐ Yes 2 🗓 No |
| | ith the Ma 23a or 28a st be notif | | MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 9003 CANBERRA DRIVE | 10f. Zip Code 20735 | | Citizen of What Country? |
| 9036 | je 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: BLACK |
| Baltimore, Maryland 21215-0036 | within 72 hou giene. er than "nat , the Medica | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of work O NOT use retired) MAKER | king | Kind of Business/Industry WN HOME |
| /land | d be filed Mental Hyg arked oth | To Be | 17. Father's Name (First, Middle, Last) DENNIS CASON HOPKINS SR. | | ne (First, Middle, Maide GREENLEAF | · · |
| , Man | and 2 shoul Health and I tem 27 is ma | | LEROY LASSITER/HUSBAND 9003 | ng Address (Street and Number or Rui CANBERRA DRIVE C | LINTON, MD | 20735 |
| imore | Page 1 ar ment of Ha ant: If iter ury or oth | | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | TE CREMATION 6/26 | /2012 STE | Location - City or Town, State |
| Balt | permit. Page Department Important: I any injury o | | 21. Signature of Funeral Service Insee | 2. Name and Address of Facility LAS LFENBEIN & NEWNAM 4 BESTGATE ROAD | TING TRIBU I CREMATION NNAPOLIS, | TTES BY FELLOWS 1 & FUNERAL CARE 1 MD 21401 |
| at me | Physician/ | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | er the mode of dying, such as cardiac Eucreatie Ad | | Approximate Interval Between Onset and Death |
| * | Medical Examiner | L | resulting in death) Due to (or as a consequence of): Sequentially list conditions, | | | |
| | ecuted and transit | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. | | | |
| 09, | ate be exe ohysician a the burial | | resulting in death) Last Due to (or as a consequence of): d. | | | |
| . Box 687 | the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Jahours after death. The Purposed Director: After this certificate has been signed by the attending physician and the Purposed Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | | Ctopic pregnancy Other (specify) | | 23d. Date of delivery Month Day Year |
| ls, P.O. | uires that the signed by all be deta | by | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | o use contribute to the cause of death? 2 No 3 Probably 4 Unknown |
| Division of Vital Records, | The law ate has page 2 | Completed | | | 24a. Was an autopsy performed 1 Yes 2 | |
| ta | ician: certific rector, | Be | 25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 26. Place of Death (Chec | 3.4 | _ |
| n of V | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | cate: To | 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 2 ☐ Accident Investigation | nt 3 ☐ DOA | ome 5 Residence 28d. Describe how in | |
| Divisio | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Certificate: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify) | reet, factory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) |
| | ne Hospita n 24 hours ne Funera pletely fille | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investoring only one) 3 Certifying Nurse Practitioner: To the best of my knowledge | stigation, in my opinion, death occurred | at the time, date and pla | ace, and due to the cause(s) and manner stated. |
| | Nithi North | | 29b. Signature and title of certifier Which is a signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and the sign | 29c, License number | 29d. | Date signed (<i>Month, Day, Year</i>) 06/25/2012 |
| _ | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Charles M. Harrism MA 60951) | Print) Lanskalee Dr. E | - Knidgl, | mp 21075 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Rygistrar's Signature | back | - / | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Benjamin S. Loeb 2 0 1 2 8:30 am Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 3701 International Drive. Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) New York 1 🛛 M 2 🗆 F Months Days Hours Min (Month, 83 / 1914 081-03-3132 98 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Silver Spring 1 🗌 Yes 2 💢 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive, #609 20906 u.s.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black White etc. 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. þ "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. Completed 3 Widowed 4 Divorced Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Nuclear Arms Control Author/Historian permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanche Frank Benjamin Simon Loeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11351 Woodglen Drive, #539, Rockville, Maryland 2085 Ellen Ruth Loeb - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Lincoln Crematory 06/20/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav 4 Pregnant at time of death 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Basa 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 X 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🛛 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Year

June

State Registrar 29a. Certifier (Check

29b. Signature and title of certifier allicia

31. Date filed (Month, Day, Yea

10ms1

Name and address of person who completed cause

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Formend#10E,19B per FHState of Maryland / Department of Health and Mental Hygiene - State Registrar6/29/12 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Rebert Doyd TOME 10:41PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMOLE BURNIE DASHINGTON MEDICAL ARUNDEL GLEN ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 0270871944 Country) Director 213-42-2223 1 X M 2 □ F 68 NC Usual Residence of Deci 10h Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Anne Arundel Millersville 10e. Street and Number Weyburn 10f. Zip Code 10g. Citizen of What Country? Funeral 8166 21108 Wayburn Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. ۾ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 6.2 timore, Maryland 21215-0036 Year or Dates. 63-82 1 ☐ Yes 2 √2 No Specify: 3 Divorced Specify: White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) LLOYD, ROBERT Elementary/Secondary (0-12) College (1-4 or 5+) Computer Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked Ricaud McKay Lloyd Dolly Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8166 Wayburn Rd Millersville, MD 21108 Donna Lloyd (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Atlantic Crematory 6/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral home P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exam the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav 1 Yes 2 No g Unknown eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🔀 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🌠 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Quillam Joe Giong per, NO D0065±1A

CH20+ State

Registrar

301 Horital Dr., 6 Don Burnie, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUICLENTO JOSE, CITARENECO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18ex Men 1922 1/1/1904 of Health and Montal Hygians

| ganal Maisu | па | " State of Maryland / 1- For State Registrar | Certificate of | | | teg. No. 2012 2240 |
|--|----------------|---|---|---|---|---|
| Physici dical Exami | | | nlal Kikabha | ai Maisuriy | | ath 3. Time of Death |
| The same of the sa | | 4a. Facility Name (if not institution, give street and number) Union Hospital | 45 | o. City, Town, or Location | | 4c. County of Death Cecil |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age 212-91-6152 1XM 2F | (In yrs. last birthday) 63 Yrs. | If Under 1 Year If Un Months Days Hou | ırs Min. | rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) India |
| ŕı | | Usual Residence of Decedent | Oc. City, Town or Location | | 1 1 0470 | 110d. Inside City Limits |
| and show any | or | Maryland Cecil | E1kton | | | 1 Yes 2 X No |
| ne Maryl or 28a-1 | Director | 10e. Street and Number 291 East Pulaski Highway | | 10f. Zip Code 2192 | | log. Citizen of What Country? United States |
| th with the cems 23a | Funeral I | 11. Marital Status 1 Never Married 2 Married Armed Forces? | | | rigin? (Specify Yes or No | |
| MOFE, MID 21215-1036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Mental Hygiene, not of Health and Mental Hygiene and: If item 27 is marked other than "natural", or items 23a or 28a-fahenr other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once | by Fur | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | X No 1 1 | res 2 X No speci | fy: | Specify: Indian |
| 72 hours | | 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5- | during mos | s Usual Occupation (Givent of working life. DO NO | | 16b. Kind of Business/Industry |
| Z 1 3-0030 be filed within 72 hor ttal Hygiene. rked other than "nat ent, the Medical Exa | Completed | Unknown 17. Father's Name (First, Middle, Last) | Nev | ver Employe | d er's Name (First, Middle, | Never Employed |
| be filed ental Hy arked of | Be | Kikabhai Maisuriya | | La | xmiben Mais | uriya |
| DAILIMOTE, MID Z1Z13-UO. Separtine 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other til injury or other traumantic event, the Med | ያ | 19a. Informant's Name/Relationship (Type, Print) Madhuben Maisuriya / Spouse | | | umber of Rural Route Nur 291 East Pi _21921 | nber, City or Town, State, Zip Code) ulaski Highway |
| Ore, I ges 1 and t of Healt t of Healt ther tra | | 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State | E1kton 20b. Place of Dispositi LeRoy P • Wo | | June 23, | 20c. Location - City or Town, State |
| Dalumore, permit. Pages l ar Department of Hee Important: If ite | | 4 Donation 5 Other Specify: 21. Signature of Euneral Service Licensee | | me and Address of Faci | Crouch Fun | Atco, New Jersey eral Home, P.A. |
| លិ ឱ ី ∄ ∄ Physician | | 23a. Part I. Bnter the disease, or complications that caused the | | | | rth East, Maryland2190 rest, shock, or heart Approximate Interval |
| /Medical Examiner | | failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries | | | | Between Onset and Death |
| | | or condition resulting in death) Due to (or as a consection b. | uence of): | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated | | | | |
| cuted ind transit | | events resulting in death) Last Due to (or as a consected d. | uenca of); | | | |
| bu, te be exe ysician a burial - | ledical | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome | of pregnancy | | | 23d. Date of delivery |
| VECOIDS, P.O. BOX 06/00, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown | 2 Fetal | I death 3 Ector | pic pregnancy | Month Day Year |
| ires that the d signed by the | by Phy | Part II. Other significant conditions contributing to death | out not resulting in the und | derlying cause given in I | | obacco use contribute to the cause of death? s 2 ✔ No 3 Probably 4 Unknown |
| requires been sign hould be | eted | | | | 24a. Was | an 24b. Were autopsy findings available |
| ng Physician: The law requir free this certificate has been s neral director, page 2 should I | Completed | | | | | rmed? death? 2 No 1 Yes 2 No |
| sician: The is certificate irector, page | å | 25. Was case referred to medical examiner? | 2 V ER/Outpatient | | h (Check only one) Nursing Home 5 | Residence 6 Other: |
| | n: To | 27. Manner of Death 28a. Date of Injury CMonth: Day, Yes | | ury 28c. Injury at Wo | rk? 28d. Describe | how injury occurred struck by a mini van |
| tal or Attendii rs after death. al Director: / | Certification: | 2 Accident Investigation Jun 19, 2012 | 2125 hrs ry - At home, farm, street, | 1 Yes 2 factory, office building, | etc, 28f. Location (| Street and Number or Rural Route Number, City |
| To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the | | 4 Homicide determined (Specify) Majo | r Road / Highway | | 77 | State) Pulaski Hwy, Elkton, MD |
| To the How within 24 h To the Fur completely | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. | | | | |
| F S F S | ž | 29b. Signature and title of certifier | · | 29c. License number | er | 29d. Date signed (Month, Day, Year) June 20, 2012 |
| ς | | 30. Name and address of person who completed cause of dea | ath (Item 23a) | O.C.IVI.E. | <u>-</u> | June 20, 2012 |
| 5 | | Pamela E. Southall, MD Assistant Medic | | N. Baltimore Stree | et, Baltimore, MD 2 | 1223 |
| St Regist | ate trar | 31. Date filed (Month, Day, Year) 32. Registrar's | Signature A. Lan | and and | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 27, 2012 George Ear1 Morris 6:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9901 Turret Lane Prince George's Clinton Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Davs (Month, Day, Year) 075-32-3844 75 **Director X**X M 2 □ F Mar. 25, 1937 Virginia Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 XXIo Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9901 Turret Lane Funeral "natural", or items 23a 20735 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 1965 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea Elementary/Secondary (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Corner Morris Lucy Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lina R. Morris/Wife 9901 Turret Lane, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 Donat on 5 Other (Specify) Veterans Cemetery 7/2/2012 Cheltenham, MD 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatu A 6160 Oxon Hill Road Oxon Hill, Maryland Part 1. Phter the disease, or complications that cause shock, or heart failure. List only one cause on each li o not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** S. quentially list conditions if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Vear 5 Other (specify) 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5xx Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 1 X X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number D2c35

State Registrar

(0

6 *1

30. Name and address of person

JUN 2 8 2012

who completed cause of death (Item 23a) (Type, Print)

| | | | | | Type or | | | | | | | | | _ | ible. | | |
|----------------------------|--|----------------------|---|---|---|--------------------------------------|---|--|--------------------|----------------------|-----------|--------------------------------|-------------------|--------------------|---------------------|---|-------------------|
| | | 1 | For AMEND#2 | 2016 per FH /12 AACO H | | of Marylai | | artmen <i>rtificate</i> | | | and N | fental Hy | | 20 | 112 | 22 | 1,05 |
| | Physicia Medic | | 1. Decedent's Name | | it) | arr | | imeate | 012 | Journ | | 2. Date of D Month | D | o. 20 | Year O | 3. Time of [| Death M |
| ā | Examin | | 4a. Facility Name (if n | ot institution, give | | nber) | | | | Location o | |) | 40 | c. County | of Death Arun | del | |
| T-CAMPA (| Funeral Director | | 5. Social Security Nur 214-38-07 | mber 6. Se 716 1 | | 7. Age (In yrs. 74 | last birthday) Yrs. | If Under Months | | If Under Hours | | 8. Date of B (Month, D | | 37 | Cour | place (State or ntry) vland | Foreign |
| | and show t at | ö | Usual Residence of 10a. State | Decedent 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | , | | | 10d, Inside City | / Limits |
| | e Maryl r 28a-f notified | Sirect | Maryland 10e. Street and Numb | | undel | | Annap | | | | | | | 1 ☐ Yes 2 🕱 No | | | 2 □ XNo |
| | with th | Funeral Director | | ngerview | Lane | | | 10f. Zip | Code | 214 | 401 | | 10 g . C | itizen of W USA | /hat Cou | ntry? | |
| 920 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once. | ۵ | 11. Marital Status 1 ☐ Never Marrie 3 🙀 Widowed 4 | | 12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da | 2 ∑X No re | | Was Decede f Yes, speci | ify Cuba | n, Mexican | , Puerto | cify Yes or No Rican, etc.) |)- | | k, White, | can Indian, etc. ite | |
| 15-0 | 72 hou n "natu fedical | Completed | (Speci | 15. Decedent's E ify only highest gra | ade completed) | | (Give | dent's Usua kind of worl O NOT use | k done d | ation Juring most | of worki | ng | 16b. i | Kind of Bu | siness/In | ndustry | |
| 212 | l within ygiene. ner thai t, the N | S | Elementary/Secon | | College (1 5+ | -4 or 5+) | | cher | retired) | | | | E | Educa | tion | | |
| Maryland 21215-0036 | uld be filed Mental Hy narked ott | To Be | | n Ellis | | | | | | | Ma | e (First, Middle e Bosi | e | | | | |
| , Mar | nd 2 shou lealth and m 27 is n | | | 11 - Son | vpe, Print) | | | | | and Numbe | | , Clark | | | | | |
| Baltimore, | . Page 1 a tment of H tant: If ite jury or ot | | | sition Cremation 3 Other (Specif | | State | Place of Dispo cemetery, cren Lington | natory or ot | her place | e) Cem | 7/1 | | Ar | rling | ton, | | |
| Ball | permit Depart Impor any in | | 21. Signature of Fune | eral Service Licens | "Wat | rest | | Name and 47 Du | | | | | | | | al Home MD 214 | |
| | Wedical and Medical stransit burial-transit burial- | ical Examiner | 23a. Part 1. Enter the shock, or heart Immediate Cause (F) disease or condition resulting in death) Sequentially list condition in the condition of any, leading to immode. Enter United Cause (Disease or in that initiated events resulting in death) La | failure. List only of nal ditions, neclate thing jury | a. Due to (| caused the deach line. | quence of): | | | | | r respiratory a | arrest, | | | Approximate Interval Betwo Onset and Do | een |
| . Box 68760 | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | | IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown | onths? | 23c. If yes, out | Birth 2 ☐ Fet nant at time of | tal death 3 | Ectopic p | regnanc ecify) | у | | | | 23d. Date Mon | | | ear |
| ls, P.O | iires that th signed by | d by P | Part II. Other signific | eant conditions co | ontributing to d | eath but not re | sulting in the u | inderlying c | ause giv | en in Part I | l. | | | _/ | | he cause of dea | |
| Division of Vital Records, | The law requires that the death ate has been signed by the atte pege 2 should be detached for | omplet | C | OPD | | | | | | | | per | s an opsy formed? | d d | rior to co eath? | psy findings av ompletion of car | ailable use of |
| tal | cian: T | Be | 25. Was case referred examiner? | | Hospital: | | | | | ace of Deat | th (Check | | 2 2 11 | | 103 | 2 110 | |
| of Vi | r Physi er this c | 음 | 1 🗌 Yes 2 🔑 27. Mann of Death | No | 1 🗆 28a. Date | Inpatient 2 Cof injury | 28b. Time of | | Othe Bc. Injury | 4 ∐ Nu | | me 5 PRes 28d. Describe | | | | 0 | |
| ion | Attending Physician: or death. sector: After this certifica by the funeral director. | ificat | 2 Accident | 5 ☐ Pending Investigation 6 ☐ Could not b | injury | м | work' | ? Yes 2 🗆 | | | | | | | | | |
| Divis | To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, pege 2. | Medical Certificate: | 4 Homicide | determined | 28e. Place buildii | of Injury - At h ng, etc. (Specii | (y) | | | | | City or To | wn, State | e) | | l Route Numbe | r, |
| | To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in | Medic | (Check 2 L | Certifying Phys Medical Exami Certifying Nurs | ner: On the bas | sis of examination | on and/or invest | tigation, in m | ny opinio | n, death oc | curred at | the time, date | and place | e, and due | to the ca | use(s) and mani | ner stated. |
| | To th To th comp | | 29b. Signature and tir | | -0. | in. | X | 29c. | License | number | | | 29d. Da | ate signed | | Day, Year) | , |
| | JE ON | - | 30. Name and addres | s of person who | 1 | / - | m 23a) (Type, F | Print) | 1 | 054 | 1 - | Isla. | 0 | -/ | 1 | /201 | |
| | Stat | | frederal 31. Date filed (Month, | Day, Year) | | 2 SK (eglistrar's Sigha | | DIA ? | 010 | mor | ٠ \$. | LSICI | a d | 5/ | iuu | apoli. | SMI |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 G. 1:45 a.M Junne Martin June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Buckingham's Choice Adamstown Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🗓 F 0777071925 Indiana Director 303-24-4792 86 Usual Residence of Decedent shov at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f st notified 1 Yes 2 XNo MD Frederick Adamstown 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral 6809 Shenandoah Ct. 21710 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student orientation assistant university/education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eric Erickson Grace Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Martin / spouse 6809 Shenandoah Ct., Adamstown, MD 21710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 6/28/2012 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. of Funeral Service Licen MO1222 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vasculer Physician. thero sclevotic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to initial cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Live to (or de a consequence of; Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failore 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 🔀 No After this certificate erebro vascular disease within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be (26. Place of Death (Check only one) Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 7/2009

State

(Check

only one

29b. Signature and title of certifie

vette 31. Date filed (Month, Day, Year)

JUN 2

3000

MD

32. Registrar's Signature

RELLAR

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Warren

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0058726

29d. Date signed (Month, Day, Year)

Myersville MD 21773

29c. License number

Ventrie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
 PATRICE 2. Date of Death Time of Death 9:47A N MARIE MOSER 2002012 Year Physician/ JUNE Medical **Examiner** Facility Name (if not institution, give street and number)
FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Hours **Director** 218-72-4896 1 🗆 M 2 🛣 F 53 Yrs June 28, 1958 Delaware 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗌 Yes 2 🕱 No Frederick Woodsboro Maryland 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11821 Legore Bridge Road 21798 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Baked Goods Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other မ Betty Taylor Paul L. Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $11821\ Legore\ Bridge\ Rd.,\ Woodsboro,\ MD\ 21798$ Richard A. Moser / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 23, 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory 2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part 1. Enter the all shock, or hear faill Immediate Cause (Final sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ailure. List only one cause on each line val Retween 30 Net and Death Physician/ MOXIC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events nsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Į, Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown been signed by t should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv page perform death? certificate l 2. No 1 Tyes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) _2 ZNo Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 29d. Date signed (Month, Day, Year)

14

State Registrar Marius

JUN 2

31. Date filed (Month, Day, Year)

who contributed cause of death (Item 23a) (Type,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Merle Elaine Montfort Sunealo 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Senior Livingot 11 bnokin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 06-19-1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2√2 F 86 081-20-6415 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It is Medical Examination multibut anote. Director MD Somerset Pocomoke City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8385 Courthouse Hill Rd. 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, une de 2012 (2) 1:010m 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investment Services Excutive Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Gregg Joseph Montfort 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Miles/Cousin 8385 Courthouse Hill Rd., Pocomoke City, MD 21851 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial # 2 X Cremation 3 ☐ Removal from State 06-29-2012 Salisbury, MD Salisbury Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home 21. Signature of Fungral Service Licensee 101129 CFSP 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASWI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical Merle Montfort IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔽 No

Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manafer of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 28/5 2012 0051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATESAN. 1415 . S. DIVISION ST, SALISBURY, MO DR. USITA 32. Resistrar's Signature 31. Date filed (Month, Day, Year) JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

1:01PM

Birthplace (State or Foreign Country)

NY

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

5 4 6913

Month

24a. Was an

26. Place of Death (Check only one)

autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2X No

State

this certificate has

Be

Certification: To

Medical

29a. Certifier

25. Was case referred to medical examiner?

Hospital:

eral Director: After this certification in by the funeral director,

or Attending

To the Hospital within 24 hours a To the Funeral C

DAJ 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 10, Ellis Monroe Moore 2012 5:16 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Director** 419-24-7013 1 🗶 M 2 🗆 F 87 Feb. 24, 1925 Alabama Usual Residence of Decedent show Ħ 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 X Yes 2 No Maryland Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 13308 Overbrook Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1944If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed 966 White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Chief Petty Officer Navv traumatic event. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Eddie Lee Moore permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic, once. Lilly Mae Hasty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3818 NW First Drive Deerfield Beach, FL 33442 Margaret Jean Fryer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2012 Davidsonville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Physician/ respiration disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner eumom Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to for as a soll seque ice of Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death Year 2 🗆 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Dipatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Vatural 5 Pending injury I Director: A Accident Investigation 1 Yes 2 No 2 L Acciden
3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goulet 00 State JUN 15 2012 Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Health Care Center Bowie If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Davs Hours (Month. Day, Year 145-03-2856 1 □ M 2 🖔 F **Director** Massachusetts 1918 93 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 □ No Prince George's Maryland Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13308 Overbrook Lane 20715 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates. "natural", Specify: 3 X Widowed 4 Divorced White any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Carewe Margaret Botelho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jean Fryer/ Daughter 3818 NW First Drive Deerfield Beach, FL 33442 20b. Place of Disposition (Name of cemetery crematory or other place)
Lakemont
Memorial Gardens 20a, Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2012 Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final pret and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year 9 Unknown Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? 2. No Yes 2 me No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. filled in by determined building, etc. (Specify) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature D0052760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 State Registrar

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend#20b per fh TT 7/3/12 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JUNE 23^{ay} 201^{Year} RODOLFO ANTONIO GARCIA MARTE MA Fa:O Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA g. Birthplace (State or Foreign Country) MOCA DOMINICAN REPUT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 A M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. JUNE 18 Year) 1983 29 Director REPUB UNKNOWN Usual Residence of Decedent show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location the Maryland Director or 28a-f sl 1 Tes 2 No SALCEDO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þ permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must be once. Funeral CALLE SANCHE CASA #73 DOMINICAN REPUBLIC 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 🕅 Yes 2 □ No Specify: HISPANIC Specify: HISPANIC Completed 3 Widowed 4 Divorced Year or Dates. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) PRIVATE FACTORY WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EVARI GARCIA BEATRIZ MARTE CONTERAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALLE SANCHE CASA #73, SALCEDO, DOMINICAN REPUBLIC ROVIDENCE HERMAN MIRABEL. BEATRIE MARTE CONTRERAS/MOTHER 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/6/2012 SAN ANTONIO, SAN SALCEDO 4 ☐ Donation 5 ☐ Other (Specify) CEMENTERIO VIEJO 6-5-2012 PROVIDENCE HERMAN MIRABLL 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licensee 400981 Charle 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 s that caused the dea n. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1, Enter the disease, or complica shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Wes Medical resulting in death) Due to (or as a consequence of): **Examiner** Ane Sequentially list conditions, it any local good in models cause. Enter Underlying Examiner for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? ģ Day Year Month Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAR 12 10 CENTER DRIVE. BETHESDA. MARYLAND 20892 TOPAGI

DHMH 17 Rev 7/2009

State Registrar 1. Date filed (Month, Day, 1) JUN 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ -2 Nettie P. Nicholson 2012 \neg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico costal the DICE If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 215-80-0712 Director 1 🗆 M 2 🔀 F 92 2/14/1920 MD Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland Director notified a 1 Yes 2 X No 28a-f Girdletree Worcester MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe items 23a or ner must be n ō 21829 Funeral USA 5747 Only Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic even. 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. by 1 Never Married 2 Married NCHRE Nicholson Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ☒ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 11 Homemaker Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Stella Hill William E. Pilchard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3812 Dogwood Dr., Snow HIll, MD 21863 Donald Nicholson/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Girdletree, MD 6/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Girdletree Cem. 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of Funeral Service Berlin, MD 21811 108 William St., 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PLE MYE LOWA MULTI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atten Month Vear in the past 12 months? Pregnant at time of death 5 Other (specify) 1 No Ves 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2€No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 A certificate Yes-2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after deau.

To the Funeral Director: After this committely filled in by the funeral di 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 27 Manner of Death Certificate: iniury 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA10 Ghulam 31. Date filed (Month, Day, Year)

State

Registrar

32

JUN 28

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 19a, per fh, g929 7-19-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 10:01 PM Joan Carol Newell Medical June 2012 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 228-42-4146
Usual Residence of Decedent 1 □ M 2 💢 F 78 12/31/1933 Virginia ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. Prince Georges New Carollton 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8120 Gavin Street 20748 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent 2 Armed Forces? 1 Yes 2 No 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant WSSC 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Martin Laura Yowell 19a. Informant's Name/Relationship (Type, Print)

Robert C. Newell

Robert C. Martin Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and sh Department of Health ar Important: If item 27 is any injury or other trau once. 8120 Gavin St., New Carollton, Md., 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Comfrot Cemetery: 06/26/2012 Alexandria, Virginia 21. Signature Juneral Service Licensee 22. Name and Address of Facility Everly-Wheatley Funeral Home mo1453 1500 W. Braddock Rd., Alexandria, Va., 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CORONARY ARTERY DISEASE Medical resulting in death) Examiner PULMONARY DISEASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) TOBACCO the burial-tran Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 4 ☐ Pregnant a g ☐ Unknown 5 Other (specify) Month Day Year 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work' Accident Investigation 1 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 To the I only one 29b. Signature and title Haw, MI) Do058275 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolisko. Suito 308, Glenn Dale, MD, 20169 Alavi, MD, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 22^{Day} 20T2 Frank Theodore Oresik 10:21 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c, County of Death Frederick Emmitsburg St. Catherine's Nursing Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Feb. 5, 1919 1 🔀 M 2 🗆 F Hours Min Pennsylvania 93 Yrs. **Director** 199-10-4636 Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Frederick Thurmont 1¥ Yes 2 □ No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 105 Tacoma Street 21788 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 🛣 Yes 2 □ No If Yes, Give Year or Dates. 1941–45 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than United States Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Letter Carrier Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Kolera Peter Oresik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trait Health 16245 Hamilton Station Rd., Waterford, VA 20197 Jeffrey Oresik / Son Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Resthaven Memorial Gardens 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State June 2012 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disea shock, or heart failur Immediate cause (Final disease or condition resulting in death) complications that cadeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Physician/ o mos Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Year Month Dav Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a Was an was autopsy performed? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Yes ပု 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at ¹ work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After Natural 5 Pending 2 No Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Partifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

5+ IVA State Registrar 29b. Signature and title

Mame and address

an Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a)

2

DHMH 17 Rev 7/2009

(Type, Print)

02

29c. License number

00 1870

Rumits burg

29d. Date sigged (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Deatl Medica Year If Under 24 Hrs.
Days Hours Min. If Under Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 093-10-8461 **Director** 1 X M 2 □ F 8/7/1914 NEW JERSEY 97 or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1107 RIVER CRESENT DRIVE 21401 UNITED STATES death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) NATIONAL SALES MANAGER EXXON CHEMICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT PFLUGH JOHANNA KAHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 4 LINDSAY COURT CHATHAM, NJ 07928 BARBARA SIMPSON/DAUGHTER Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1
Burial 2
Cremation 3
Removal from State CHESAPEAKE CREMATION injury or Department of Important: If any injury or 6/29/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) CENTER Name and Address of Facilit LASTING TRIBUTES BY FELLOWS 21. Signature of uneral Service Lice ee NEWNAM CREMATION & FUNERAL CARE ROAD ANNAPOLIS MD 21401 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions. n any, leading to immedicause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending property for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) 9 Unknown the 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 1 Inpatient 2 🗌 ဂ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Investigation Accident after death Director: / in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined a 24 hous. the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) Weakland Jennifer, of death (Item 23a) (Type, Print) Name and address of person who completed cause

Registrar

DHMH 17 Rev 06-2011

State

JUN 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ PLANK 45 AM Zenz Medical y Name (if not institution, give street and numbe Examiner 4b. City. Town. or Location of Death 4c. County of Death Northwest Hospital Center B<u>altimore</u> <u>Randallstown</u> Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) Director 443-30-3417 1 🛛 M 2 🗆 F 82 Usual Residence of Deceden 10/8/1929 PAor then "neturel", or items 23e or 28a-f show the Medical Examinar must be notified at 10a. State within 72 hours efter deeth with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Hygiene. other then "neturel", or items 23e Funeral 357 Scotland Point Road 21921 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 1957-59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Contracting Officer Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) enc Mentel F permit. Pege 1 end 2 should he I Department of Heelth end Mente Important: if item 27 is marked Mark Baylor Plank Pauline E. Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scot Plank - son 249A Fountain Street, Havre De Grace, MD 21078 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State injury Harford Memorial Gardens 7/9/2012 Aberdeen, MD 4 Donation 5 Other (Specify) neral Service Licenses 21. Signatus 22. Name and Address of Facility R.T.Foard Funeral Home, PA (_ 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as conseq Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): 12 sete has been signed by the ettending physicien end vipage 2 should be detached for use es the burlei-trensit or Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s efter deeth. I Director: After this certificete has autopsy 2 No 1 🗌 Yes completely filled in by the funerel director. 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? (2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital of within 24 hours er Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 11+1 VA ess of person who completed cause of death (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, 32. Registrar s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | For State Registrar | State | of Maryla | | artment d <i>tificate</i> d | | | /lental Hy | giene Z | 2012 | 2 2 2 4 1 7 |
|--|--------------|--|----------------------------------|---------------------------------|---------------------------|-----------------------------------|-----------------------|------------------------|--|----------------|-------------------------|--|
| Physicia | n/ | 1. Decedent's Name (First, Middle | . / | | | | | | 2. Date of De | | Year | 3. Time of Death |
| Medic Examin | | Gail Masemore 4a. Facility Name (if not institution, | | mber) | | 4b. City, Tow | n, or Location | on of Death | June | | 1 Z | 3:34 A M |
| 1. | | 135 Creswell A | | | | | kton | | | Ce | cil_ | |
| Funeral Director | | 5. Social Security Number 212–38–1354 | 6. Sex 1 ☐ M 2 🕱 F | 7. Age (In yrs. 71 | last birthday) Yrs. | If Under 1 Y | ear If Undays Hour | der 24 Hrs. rs Min. | 8. Date of Bir (Month, Da 7/10/1 | | 9. Birth | place (State or Foreign htry) MD |
| nd how at | 'n | Usual Residence of Decedent 10a. State 10b. County | | | ity, Town or La | cation | | | .,,207. | | 1. | 10d. Inside City Limits |
| // Aarylar 8a-f sl tified | Director | MD Cecil | | 1,00.0 | * | kton | | | | | | 1 ☐ Yes 2 🍱 No |
| h the N Saor 2 Se no | al Di | 10e. Street and Number | | I . | | 10f. Zip Co | | | I | 10g. Citizen o | | ntry? |
| ath wit ems 2; r must | Funeral | 135 Creswell A | | edent Ever in U | S 13 | | 921 | Origin? (Spe | ecify Yes or No- | US | A lace - Americ | oon Indian |
| ifter de ", or its amine | þ | 1 Never Married 2 Marr | ried Armed Fo | orces? | | f Yes, specify 0 1 ☐ Yes 2🏖 | Cuban, Mexi | ican, Puerto | Rican, etc.) | В | lack, White, | etc. |
| hours a | leted | 3 🖾 Widowed 4 🗌 Divorced | Year or D | ates. | | dent's Usual Oc | | y. | | Spec | | |
| hin 72 l he. than "r Mev | Completed | (Specify only highe Elementary/Seconday (0-12) | st grade completed College (1 | | (Give life, D | kind of work do O NOT use reti | one during n ired) | nost of work | ing | | | uusuy |
| Hygier Hygier other t | Be C | 12 17. Father's Name (First, Middle, L | .ast) | | Cler | c of Co | | other's Nam | e (First, Middle, | · | unty | |
| d be fill Mental Mental arked | ၉ | Richard Masemo | ore | | | | - 1 | | haffer | Walder Garria | | |
| Vicinity Should the and Italian mutaums | | 19a. Informant's Name/Relationsh | | | 1 | _ | | | al Route Numbe | - | | Code) |
| 1 and 1 and 3 Healt item 2 other | | Findley McCool 20a. Method of Disposition | | 20b. | Place of Dispo | sition (Name o | f | 1 | E1ktor | 20c. Locatio | | own, State |
| perfull for the first plant of a factor of the many | | 1 🔀 Burial 2 🗌 Cremation 4 🗌 Donation 5 🗍 Other (S | | Otate | cemetery, cree Lkton C | - | | 6/29 | /2012 | E1kton | , MD | |
| permit Depart Import any in | | 21. Signature of Funeral S | icensee | | 22 | Name and A | | | .T.Foar | | | |
| | Н | 23a. Part 1. Enter the disease, or shock, or beart failure. List of | complications that | caused the dea | th. Do not ent | | | | | | 2192 | Approximate |
| Physician/ | | Immediate Suse (Final disease or ondition | a. | Brook | ist Co | mcer | | | | | | Interval Between Onset and Death |
| Medical Examiner | | resulting in death) | Due to | (or as a consec | quence of): | 540 | | | | | | 7 |
| 7161= | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to | (or as a consec | quence of): | | | | | | | |
| ecuted and I | Examiner | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Due to | (or as a consec | quence of): | | | | | | _ | |
| cate be executed physician and F | dical | | d | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | /Med | IF FEMALE: | 23c. If ves. ou | tcome of pregn | ancv | | | | | | | |
| Seath c e atten | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No | 1 ☐ Live 4 ☐ Preg | Birth 2 Fe gnant at time of | tal death 3 [| Ectopic preg Other (specif | | | | | Date of delive Month | ery Day Year |
| at the c | | 9 ☐ Unknown Part II. Other significant condition | 9 Unk | | sulting in the I | inderlying caus | e given in P | art I | 000 Did t | | | ne cause of death? |
| uires that signed Id be d | d by | | | | | | o given iii i | | | | | bably 4 Unknown |
| aw requas beer 2 shou | Completed | Elen | rtension ral | husion | / | | | | 24a. Was | | o. Were auto | psy findings available mpletion of cause of |
| The Is cate his ; page | | | C | 00 | | | | | nerfo | ormed? 2 No | death? | |
| /sician s certifi | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | Inpatient 2 | ER/Outpaties | | 6. Place of D | , | me 5 Resi | dance 6 🗆 0 | Ab /Oif | |
| ing Phy ifter this | | 27. Manner of Death 1 Natural 5 Pendin | 28a. Date | | 28b. Time of injury | 28c. I | Injury at work? | | 28d. Describe I | | |) |
| Attendi death ctor: A y the fu | Certificate: | 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could | not be | e of Injury - At h | nome farm str | | 1 Yes 2 | ! □ No | 28f Location (| Street and Num | abor or Pumi | Route Number, |
| tal or / rs after al Dire ed in b | | 4 Homicide determ | | ing, etc. (Speci | | 501, 14010/3, 011 | | | City or Tov | | ibei oi nuiai | noate Numbel, |
| Hospi 24 hou Funer eted fill | Medical | (Check 2 L Medical E | Physician: To the ba | sis of examination | on and/or inves | tigation, in my o | pinion, death | h occurred at | the time, date a | and place, and | due to the car | use(s) and manner stated. |
| To the within To the comple | Σ | only one) 3 ☐ Certifying 29b. Signature and title opertifier | Nurse Practioner: | To the best of n | ny knowledge, | 29c. Lic | ense numbe | er | | 29d. Date sign | ned (Month, i | Day, Year) |
| 6 | | Jack | ider-5. | MD | | \mathcal{J} | 0023 | 3322 | | | .25.8 | 20/2. |
| | | 30. Name and address of person v | EV MD, | 126 4 | m 23a) (Type, F | rint) ligh Si | 7, 1 | Elh | Con M | 102192 | 2/. | _ |
| Stat Registra | | 31. Date filed (Month, Day, Y | 27 2012 | Registrar's Signa | ature | 1 | | | | | | |
| negistra | П | | | Lena | TO B. | Back | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Month Physician/ Pappaconstantinou 22 $9:45 \text{ p.m}^{M}$ Charles Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 013-30-2254 Director 1 X M 2 □ F 73 04/27/1939 Massachusetts Usual Residence of Deced e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Charles Waldorf Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20601 3473 Forest Glenn Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Engineer marked other Be th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Angelo Pappaconstantinou Sophie Panas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is Charles W. Pappaconstantinou/Son 42343 Alan Lane, Mechanicsville, MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Charles Memorial Cem 106/28/2012 | Leonardtown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Danielle Ward M01403 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sect line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, Completed 24a Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 **X**No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occur d at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

6t pro

State Registrar 30. Name and address of

Jennifer

31. Date filed (Month, Day Year)

JUN 2 6 2012

32 Registrar's Signature

June 3. June

D.O

Schmidt

on who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Leonardtown, MD

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:00 P M Parce1 Mae Shirley 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Lexington Park St. Mary's 21119 Winding Way 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 212-82-1878 1 M 2 X F 67 12/30/1944 Maryland Usual Residence of Deceder 28a-f shov 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 X No St. Mary's Lexington Park Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o 23a 20653 USA 21119 Winding Way items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black White etc. ori ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛣 No Specify: ed other than "natural", event, the Medical Exar Specify. 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done duning most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Wise Pulliam Katie Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44890 Buck Redman Rd., Callaway, MD 20620 Tammy Bowen/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Trinity Memorial Grd 6/28/2012 4 Donation 5 Other (Specify) Waldorf, MD Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 David A. Goff to polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the shock, or heart f Interval Between Onset and Death Immediate Cause (Final disease or condition Hypertensive Arterial Peripheral Disease Physician/ year Medical resulting in death) Due to (or as a consequence of): Examiner 6 years Diabetes Type II Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of Coronary Artery Disease 5 years transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of). as the burialattending physician Physician/Medical certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? ŏ Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 No Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe has page 2 or Attending Physician; The after death. this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: After X Natural 5 Pending 1 Yes 2 No eral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the within 2

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O. Registrar's Signar

Katherine A. Martin,

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

H0055958

46940 S. Shangri-La Drive, Lexington Park, MD 20653

29d. Date signed (Month. Day, Year) June 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gilbert Month Fooks Perdue Sr. Medical June 26 2:40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7152 Mount Olive Church Road Snow Hill Worcester Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 218-16-6836 1 X M 2 □ F Yrs. 88 06/06/1924 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Maryland Worcester Snow Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral 7152 Mount Olive Church Road 21863 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 🙀 Married Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event; the Medical Examin any injury or other traumatic event. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Preacher Ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. Gorman Perdue Nora Fooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia Perdue/Spouse Mount Olive Church Rd., Snow Hill, MD21863 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 6/29/12 Snow Hill, MD Mt. Olive Church Cemetery 21. Signature of Funeral Parvice Licenses 22. Name and Address of Facility
Holloway Funeral Home Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospitel or Attending Physician: The lew requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day director, page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autop performed 'as 24 No certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 X No ၉ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

State Registrar 31. Date filed (Month, Day, Year,

28

12-04600 Malcolm Polk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 22421

| December Server (First, Mother, June) Policy | | | 1- For State Cel | rtificate of Dea | th | | Re | g. No. | 201 | |
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| Source Security Number S | | | , , | | | cation of Deat | | | • | |
| The company of the property | Euperal | | · · · · · · · · · · · · · · · · · · · | last birthday) If Unc | der 1 Year | If Under 24Hrs | s. 8. Date of Bir | | - | place (State or |
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| Physician Phys | re, l 11 and 11 Heals 11 item er tra | | | | | tery, | Date | 20c. L | ocation - City or | Fown, State |
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| Physician Marked Cal Examiner The Committed State Character Characte | Salti epartn nport | | | 22. Name and | d Address of | Facility Jo | hnson & | Jen | kins Fur | neral Home |
| The discussion of the contribution of the cont | | - | 22a Bed I. Enter the disease or samplingtions that caused the death | 716 Ke | nnedy | St. N. | W. Washi | ingo | tn. DC 2 | Approximate Interval |
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| Suicide 6 Could not be determined (Specify) Local Street Could not be determined Could not | ding Afte | 틸 | May 31, 201 (Month, Day Year) | 1 ' ' | | | | | | е |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 22, 2012 30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | Signature Atternation of the Signature o | icat | 2 Accident Investigation 28e. Place of Injury - At h | lome, farm, street, factor | y, office buil | ding, etc. | 28f, Location (S | Street ar | nd Number or Run | al Route Number, City |
| 29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner: 900 W. Baltimore Street, Baltimore, MD 21223 | Is a r | F | Suicide Could not be determined (Specify) Local Stro | | • | | or Town, S Edwin Street a | itate) and Ce | nterhill Street, \ | Wheaton, MD |
| 290. License number O.C.M.E. June 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | the Hosp nin 24 hou the Fuoei upletely fi | _ | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowled | | | | | | | |
| 30- Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | To with | Med | | 29 | c. License r | number | | 29d. E | Date signed (Mon | th. Day, Year) |
| 30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | | | (X istoho in) | | O.C.M. | E. | | June | 22, 2012 | |
| Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | 90 | - | O go to to College | n 23a) | | | | | | |
| State 31 Date filed (Month Day Year) 32. Registrar Signature | | | Laron Locke MD. Assistant Medical Examiner | 900 W. Baltimor | e Street, | Baltimore, | MD 21223 | | | |
| Registrar JUN 2 0 2012 Annua P. Maria | | ite | 31 Date filed (Month, Day Year) 32. Registrary Signat | bake | , | | | | | |

00ME

| 12-04912 Maurice Proctor | | Please Type or Print in Blac State of Maryland / D | | | | | gible. | |
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| | | 1- For State Registrar | Certificate of | | nd Mental | | eg. No. 20 | 12 221 |
| Physiciar | n/ | Decedent's Name (First, Middle,Last) | | | | 2. Date of Deat | th | 3. Time of Death |
| Medical Examin | er | Maurice Proctor 4a. Facility Name (if not institution, give street and number) | | b Oits Town | - Landing of D | June 30, 2 | | 2239 hrs |
| mand | | Prince George's Hospital | 4 | Cheverly | or Location of De | atn | 4c. County of Dea Prince Georg | |
| Funeral | 7 | 5. Social Security Number 6. Sex 7. Age (In | n yrs last birthday) | If Under 1 Y | ear If Under 24 | Hrs. 8. Date of Birt | th(MM/DD/YYYY) 9. B | |
| Director | -1 | 577-80-8180 1XM 2F | 53 Yrs. | Months Da | ays Hours N | July 5 | , 1958 Fore | ign ^{ountry)} DC |
| b | I | Usual Residence of Decedent 10a. State 10b. County 10c | c. City, Town or Location | | | 1 | | 10d. Inside City Limits |
| inw any | . | | . Oity, rown or Locatio | | Man | .15 | | 1 X Yes 2 No |
| arylan 8a-f st at onc | Director | Maryland Prince George's 10e. Street and Number | | 10f. Zip Code | pper Mar | | Og. Citizen of What Co | untry? |
| the M sa or 2 | [급 | 4309 Skipton Court | | | 20772 | | United St | ates |
| death with the Maryland or items 23a or 28a-f shnw must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Forces? | | | | Specify Yes or No- | | rican Indian, Black, |
| er dear | | Never married 2 1 Name 1 1 X Yes 2 1 Nidowed 4 Divorced If Yes, Give Year | No | Yes 2 X | | , | | 1- |
| urs aft tural" | <u>۾</u> | 15. Decedent's Education (Specify only highest grade comple | ted) 16a. Decedent | 's Usual Occup | ation (Give kind | | Specify: B1a | |
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| 5-0036 iled within 7 Hygiene. I other than the Medica | Completed | 12th | Pı | rinter | Operator | | Priv | ate |
| 215- be filed ntal Hyg rked off | ğ Be | 17. Father's Name (First, Middle, Last) Everett Proctor | | | 18.Mothers Na | me (First, Middle, N | naiden Surname) eneva Digg: | g |
| 7 달림 월 달 [] | | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | Address (Str | eet and Number | | ber, City or Town, Stat | |
| MD d 2 sho lith and n 27 is | 1 | Tremyl Proctor - Wife | | | | - L L | arlboro, M | |
| MOCE, Pages an nent of Hea ant: If ite | | 20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State | 20b. Place of Disposit crematory or other | er place) | I 05 | Date 7-10-2012 | 20c. Location - City of | r Town, State |
| time treet treet rent | Ī | 4 Donation 5 Other Specify: 41714. | Glenwood (| Cemeter | Yhk. | -unk . | Washingt | on,DC unk. |
| Balti permit. Departm Impurta | | Moo. | | | • | | Funeral Hoshington, | |
| Physician | | a. Part I. The disease, or complications that caused the failure. List only one cause on each line. | | e mode of dyin | g, such as cardia | c or respiratory arre | est, shock, or heart | Approximate Interval |
| /Medical Examiner | - | Immediate Cause (Final disease a Cardiac Arri | ythmia | | | | | Between Onset and Death |
| Books h | | or condition resulting in death) Due to (or as a consequence) | ence of): | | | | | |
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| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence) | ence of): | | | | | |
| executed an and al - transit | ă | d | | | | | | |
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| ox 68760, ath certificate be extated attending physician or use as the burial | | IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth | _ | al death 3 | Ectopic preg | nancv | 23d. Date of deliver | Ty Day Year |
| ox 6 | S | past 12 months? | e of death | er (Specify) | | | | , |
| that the death need by the att detached for | چ چ | Part II. Other significant conditions contributing to death but | t not resulting in the ur | derlying cause | a diven in Part I | 23e Did to | bacco use contribute to | the cause of death? |
| P.O es that gened by the detay | 2 | , and the state of | thotrosaking in the di | identy in ig odda. | given in react. | 1 Yes | | babiy 4 V Unknown |
| tal Records, P.C. cian: The law requires that certificate has been signed extor, page 2 should be deter | Completed | | | | <u> </u> | 24a. Was a | | utopsy findings available |
| eco he law nte has | 틹 | | | - | | autops perform | med? death? | completion of cause of |
| ician: The cician: The cicion of certificate rector, page | ပ္သံ - ရွိ | 25. Was case referred to medical | | 26.Pla | ce of Death (Che | | | |
| of Viting Physici ing Physici After this c | <u> </u> | Tes 2 No | 2 ER/Outpatient | | | sing Home 5 7 | | er: |
| n of ding Ph. h. After t funeral | | 27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) | 28b. Time of Inj | | jury at Work? Yes 2 No | 28d. Describe h | ow injury occurred | |
| ivisior or Attendather death Director: | ة | 2 Accident Investigation 28e Place of Injury | - At home, farm, street | | | 28f. Location (S | treet and Number or R | ural Route Number, City |
| Divi | Certification: | 4 Homicide Could not be determined (Specify) | | | O. | or Town, St | | |
| | Medical C | 29a. Certifier 1 Certifying Physician: To the best of my kn one) 2 Medical Examiner: On the basis of examination | owledge, death occurre | ed at the time, on, in my opinio | date and place, a on, death occurre | nd due to the cause d at the time, date a | e(s) and manner as sta and place, and due to t | ted. ne cause(s) |
| F. 18 6 2 | Σ Σ | and manner stated. 29b. Signature and title of certifier | | 29c. Licer | nse number | | 29d. Date signed (Mo | onth, Day, Year) |
| | | OmeZ | | O.C.M.E. July 1, 2012 | | | | |
| | | 30. Name and address of person who completed cause of death | | A/ Dali: | ro Circot Del | timore AAD 04: | 222 | |
| Sta | to. | Ana Rubio M.D., Ph. D. Assistant Medical 31. Date filed (Month, Day, Year) 32. Registrar's S | | vv. Daitimo | e Sheet, Bai | timore, MD 21: | 223 | |
| Registra | ar | 31. Date filed (Month, Day, Year) 32. Registrar's S | Signature | | | | | |

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dangelese Chuck Pinkston State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Medical Examiner D'Angelese Chuck Pinkston Year June 30, 2012 1313 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Foreign Kentucky
Country) Months Davs Hours 401-84-0368 1 X M 2 57 Yrs. 10-05-1954 Ohio Usual Residence of Decedent 10a State Oc. City, Town or Location 10d. Inside City Limits 28a-f show MD Montgomery Burtonsville 1 X Yes 2 No death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14633 Monmouth Drive 20866 USA 238 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black. Armed Forces? 2 XMarried If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Xyes Pages 1 and 2 should be filed within 72 hours after Divorced If Yes, Give Year 976-1984 3 Widowed Black Yes 2 X No specify: Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Audio Technician Private Industry of Health and Mental Hygiene.

If item 27 is marked other the other the other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Pinkston Geraldine Dole 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address. (Street and Number of Rural Route Number, City or Town, State, Zip Code) Kimberly Pinkston (Wife) Burtonsville, Maryland 20866 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 artment c RiverdalePk.Crem. 07-10-201 2 Riverdale, MD Other Specify. Ě Donation 5 lature of Funeral Service Lice Ralph Williams, II Funeral Service, 5202 PrincetonsDelightDr., Bowie, MD PrincetonsDelightDr., Bowie, MD 20720 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval /Medical Between Onset and Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, per me, g929 7-27-12 sm #9.per fh. g930 8-3-12 sm X UNPENDED the attending physician ed for use as the burial Box 68760, IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? 2 Month Day Year Pregnant at time of Other (Specify) Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> ۵ Yes 2 No 3 Probably 4 V Unknown Records, Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) examiner? Other₄ this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes Residence 6 Certification: To No After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural To the Funeral Director: completely filled in by the Pending within 24 hours after death. Yes 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 1, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State | State of Ma | ryland / Depa | | | Mental Hyo | giene | |
|--------------------------------|---|----------------|--|---|----------------------------------|--|--|----------------------------------|----------------------|--|
| | | | Registrar | (00t) | Cer | tificate of L | <i>Death</i> | T | Reg. No. | 12 22424 |
| н | Physicia | n/ | Decedent's Name (First, Middle Timothy | | | | | 2. Date of Dea Month | Day | 3. Time of Death 1:36 A M |
| April 10 may | Medic Examin | | Timothy 4a. Facility Name (if not institution | Rogers | | 4b. City. Town, or | Location of Death | June_ | 26, 20: | |
| | Examini | ei | St. Mary's | , | | | ardtown | | | Mary's |
| - | Funeral | | 5. Social Security Number | | (In yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birtl (Month, Day | Year) | Birthplace (State or Foreign Country) |
| | Director | | 250-76-8227 | 1 x M 2 □ F | 65 Yrs. | MIGHTIO Days | 110010 | 4/6/19 | | South Carolina |
| | nd how at | ا _ا | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Loc | ation | | | | 10d. Inside City Limits |
| | lanyla Ba-f s tified | Director | Maryland St | . Mary's | Mecha | nicsvill | .e | | | 1 🗆 Yes 2 👿 No |
| | the N | | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of W | · |
| | n with | Funeral | 26360 Tin Top | School Road | | 1 | 659 | | US | Α |
| | is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show of other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | | 11. Marital Status 1 Never Married 2 X Mar | 12. Was Decedent Ev Armed Forces? | If | Vas Decedent of H f Yes, specify Cuba | ispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | - American Indian, , White, etc. |
| 336 | al", o | d by | 3 ☐ Widowed 4 ☐ Divorced | If Yes Give | NO 1 | ☐ Yes 2 🗷 No | Specify: | | Specify: | Black |
| 9-0 | hours natur fical I | Completed | | nt's Education | 16a. Deced | lent's Usual Occup | ation | kina | 16b. Kind of Bus | siness/Industry |
| 218 | iin 72 ie. han " e Mec | 티 | Elementary/Secondary (0-12) | est grade completed) College (1-4 or 5- | life DC | O NOT use retired) | | King | Educa | ation |
| 121 | filed within 73 al Hygiene. d other than event, the Me | BeC | 47 February November 1 States | | Mt | usic Teac | | on (First Adjusted) | | TCION |
| anc | 2 should be filed th and Mental H 27 is marked ot traumatic even | 일 | 17. Father's Name (First, Middle, John Ro | gers | | | Alice | | Maiden Surname) Wise | |
| ary. | ould l | | 19a. Informant's Name/Relations | | 19b. Mailin | a Address (Street | and Number or Ru | ral Route Number | ; City or Town, Sta | ate, Zip Code) |
| ž | d 2 sh alth ar 27 is | | Catherine Rog | | 2636 | Ö Tin Top | School | Rd., Med | chanicsv | ille, MD 20659 |
| Je, | ge 1 and 2 should be nt of Health and Ments: If item 27 is marked or other traumatic e | | 20a. Method of Disposition | 0 □ D | 20b. Place of Dispos | sition (Name of natory or other place | ce) | Date | 20c. Location - 0 | City or Town, State |
| <u>iii</u> | Page ment ant: It | | 1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other (| | Charles l | | | 2/2012 | Leonar | dtown, MD |
| Baltimore, Maryland 21215-0036 | permit. Page Department or Important: If any injury or once. | | 21. Signature de la rai dic | David A | A. Goff | Name and Addre Matting 41590 Fe | ss of Facility Ley-Gardi nwick St | ner Fund , Leona | eral Home | P.A.50 MD 20650 |
| | | | 23a. Part 1. Enter the disease, o | r complications that caused only one cause on each line. | the death. Do not ente | er the mode of dyin | g, such as cardiac | or respiratory arr | est, | Approximate Interval Between |
| | hysician/ | | Immediate Cause (Final disease or condition | | Respirato | | | | | Onset and Death |
| | Medical Examiner | | resulting in death) | | consequence of): | | | | | |
| | | je er | Sequentially list conditions, | D. — | ary Emboli consequence of): | SM | | | | |
| (7) | red | Examiner | if any, leading to immediate cause. Little Underlying Cause (Disease or injury | G I B1 | | | | | | |
| | execuin and ial-tra | E | that initiated events resulting in death) Last | , | consequence of): | | | | | |
| 09 | The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit | edical | | d. Atrial | Fibrillat | ion | | | | |
| 87 | rtifical ing ph e as tl | /Me | IF FEMALE: | 20- 15 | | | | | | |
| Box 687 | ath certifice attending p | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of Live Birth 2 | 2 🗌 Fetal death 3 🗀 | Ectopic pregnand Other (specify) | су | | 23d. Date Mon | of delivery th Day Year |
| ğ | that the dea led by the a detached f | Physician/M | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9 Unknown | time of death 0 = | 3 Other (apociny) _ | | | | |
| P.O. | that the | by Pł | Part II. Other significant conditi | ons contributing to death bu | ut not resulting in the u | nderlying cause gi | ven in Part I. | 23e. Did to | bacco use contrib | oute to the cause of death? |
| S, | v requires that been signed be should be det | ed E | | | | | | 1 🗆 ' | Yes 2□No | 3 Probably 4 Unknown |
| Sor | has bee | Completed | | | | | | 24a. Was a | | ere autopsy findings available for to completion of cause of |
| Re | The la ate ha page | Con | | - | | | | 1 Perfo | rmed? de 2 No 1 | eath? |
| tal | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | Oth | lace of Death (Che | | | |
| Ϋ́ | Phys this ral di | 6 | 1 Yes 2 No 27. Manner of Death | 1 Unpatie | ent 2 ER/Outpatien 28b. Time of | nt 3 🗆 DOA | 4 U Nursing F | | lence 6 Other | |
| n o | ling In. After fune | cate | 1 Natural 5 ☐ Pendi | 0.4 . 11. 15 | | worl | | 200. Describe ii | ow many become | |
| Division of Vital Records, | I or Attending Phy after death. Director; After this d in by the funeral d | Certificate: | 3 Suicide 6 Could 4 Homicide detern | not be | ry - At home, farm, stre | eet, factory, office | | | | or Rural Route Number, |
| Ρį | tal or rs afte al Dir led in | | | building, etc | . (Specify) | | | City or Tow | | - h |
| | To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b | Medical | (Check 2 Medical | g Physician: To the best of a Examiner: On the basis of examiner: To the g Nurse Practitioner: To the | camination and/or invest | tigation, in my opini | on, death occurred | at the time, date a | nd place, and due | to the cause(s) and manner stated. |
| | To the within To the complete | 2 | 29b. Signature and title of certifie | | | 29c. Licens | | | | (Month, Day, Year) |
| | | | 1 2081 | w | | D4 | 7066 | | June 26 | , 2012 |
| | prne | | 30. Name and address of person | | | | nert In- | nordto- | Mm 204 | .50 |
| 10) | Sta | te_ | Avani D. Sh 31. Date filed (Month, Day, Year) JUN 2 7 | | 22650 Cedar | | urt, Leo | Halutown | , FID 200 | |
| | Registr | | JUN 27 | 2012 Can | r's Signature | wes | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 06/28/2012 Physician/ 12:48 p.Mm William Ross Ralev Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** St. Mary's 49755 Bayne Road Ridge 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs 1 🖾 M 2 🗆 F Director 577-26-5839 Yrs 01/07/1917 Maryland Usual Residence of Deceden 95 items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland 10a State 10c. City. Town or Location Director 1 Yes 2 X No Maryland St. Mary's Ridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20680 49755 Bayne Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Deceusin ___ Armed Forces? 1 X Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Yes 2 If Yes, Give Year or Dates by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. 3 XWidowed 4 ☐ Divorced White Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic Elementary/Secondary (0-12) College (1-4 or 5+) Store Merchant 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mignonette Marie Raley William Calvert Raley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20680 49725 Bayne Road, Ridge, MD Raymond Raley/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Michael's Cem 07/02/2012 Ridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield Funeral Home, P.A. MD 20650 Mireolurer Service insee Michele Brinsfield 22955 Hollywood Road, Leonardtown, MD M0165 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No signed by the a Id be detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural Acciden 5 Pending n 24 hours after was ne Funeral Director. After maletely filled in by the further forms of the f 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 29b. Signature and title of certifier

30. Name and address of perso

Jennifer

D.O. Schmidt 31. Date filed (Month, Day, Year)

40900 Merchants Lane, Leonardtown, MD

pleted cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20650

| | | 1- For State Certificate of Death | Reg. N | 201 | 2 2242 |
|--|----------------|--|------------------------|-------------------------------------|---------------------------------------|
| Physic | | Decedent's Name (First, Middle,Last) | 2. Date of Death | | 3. Time of Death |
| ledical Exam | inei | GHEISEA EITH ROBERTSON | June 26, 2012 | | 1650 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 45763 Belvoir Road Great Mills | | 4c. County of Death | |
| F | | | 10.0 | St. Mary's | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. | | M/DD/YYYY) 9. Birt Foreig | n |
| | ŀ | 322-07-8810 1 M 2XF 23 Yrs. | 10/1/1988 | 8 Cou | untryColorado |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location | | | 404 Inside Oil Linis |
| * . | | MD Ct Marry C | | | 10d. Inside City Limits 1 Yes 2 X No |
| faryland | ខ្ន | MD St. Mary's Great Mills 10e. Street and Number 10f Zip Code | | | |
| th the Maryland 23a or 28a-f sho notified at once. | Director | 10e. Street and Number 10f. Zip Code | | itizen of What Coun | - |
| th the 23a o | O K | 45763 Belvoir 20634 | | ited Stat | es |
| tems | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R | | 14. Race - Americ White, etc. | can Indian, Black, |
| er der , or i | | | | L. Wh | ite |
| 5-0036 led within 72 hours after death with the Maryland Hygiene, other than "natural", or items 23a or 28s-f she the Medical Examiner must be notified at once | b | 3 Widowed 4 Divorced lit Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo | ork dona 16h | Specify: W [] . Kind of Business/Ir | |
| 2 hou | eted | Elementary/Secondary (0-12) College (1-4 or 5+) | | . Kind of Business/if | idustry |
| 036 ithin 72 ne. r than ' | 츁 | Never Worked | | Never Wor | ماد م تا |
| 5-0(led wil tygier other | Comple | 17. Father's Name (First, Middle, Last) 18.Mother's Name (I | | | . Keu |
| it ked | Be | Kenneth Edwin Robertson, Jr. Kimberle | y Kay H | land | |
| MD 21 12 should by and Mer 127 is mar | ٩ | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru | | | Zip Code) |
| e, MD 2 and 2 shoul lealth and M item 27 is m | | Kimberley Robertson (Mother) 45763 Belvoir Road, G | reat Mill | s, MD 206 | 34 |
| s l and 2 of Health If item 2 | | | | Location - City or | |
| Baltimore, Permit. Pages I an Department of Hea Important: If iter | | | 0/2012 C | harlotte | Hall MD |
| Baltimo permit. Page Department c Important: injury or oth | | 21. Signature of Funeral Service Licensel () March 1 22. Name and Address of Facility Brin | nsfield F | uneral Ho | me. P.A. |
| E F P E | | Danielle Ward M01403 22955 Hollywood Roa | | | |
| Physician | Ť | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r failure. List only one cause on each line. | respiratory arrest, sh | nock, or heart | Approximate Interval |
| /Medical Examiner | | Immediate Cause (Final disease as a Complications of Chronic Alcohol Abus | | | Between Onset and Death |
| LAGIIIIIGI | | or condition resulting in death) Due to (or as a consequence of): | | | |
| | <u>.</u> | Sequentially list conditions, | | | |
| | Examiner | if any, leading to immediate Due to (or as a consequence of): Consecutive First Underlying Course C. C. | | | |
| n .5 | xan | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| ecute and trans | | d | | | |
| 760, Icate be executed physician and the burial - transit | /Medical | X UNPENDED AMENDED 23a, 27, per me, g929 7-30-12 sm | | | |
| 760, ficate be g physic the bun | | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the | | 3d. Date of delivery | |
| certif | ia | past 12 months? | ey . | Month Da | ay Year |
| Box 68 death certiff the attending ed for use as | Physiciar | 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 9 ☐ Unknown | | | |
| at the | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco | use contribute to th | ne cause of death? |
| Division of Vital Records, P.O. Box 68 and or Attending Physician: The law requires that the death certif its after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as | d by | | 1 Yes 2 | No 3 Proba | bly 4 🗸 Unknown |
| rds requi | Completed | | 24a. Was an | | ppsy findings available |
| e has | Ē | | autopsy performed? | death? | mpletion of cause of |
| I. The | | 25. Was case referred to medical 26 Place of Death (Check on) | 1 Yes 2 N | Vo 1 ✓ Yes | 2 No |
| siciar siciar is cerr | 8 | examiner? Hospital: 4 - 4 - 4 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - | | | |
| n of Vital Reccing Physician: The law After this certificate har funeral director, page 2 | P. | Yes 2 No | 3d. Describe how inj | | Scene |
| | Certification: | 1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No | | jary coodinod | |
| ivision lor Atten after death Director: | | 2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 28 | of Location (Street | and Number or Rura | I Route Number, City |
| Division ospital or Attenchours after death neural Director: y filled in by the | 1 | Suicide 6 Could not be determined (Specify) | or Town, State) | and Number of Nura | il Route Number, City |
| Hospi 24 hou Functiely fil | | 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du | e to the cause/s) ar | nd manner as states | |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical | one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the | | | |
| F F F S | ₩ R | 29b. Signature and title of certifier 29c. License number | 29d. | Date signed (Monti | h, Day, Year) |
| | | (| Jun | ne 27, 2012 | |
| | H | 30. Name and address of person who completed cause of death (Item 23a) | | | |
| | | Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M | D 21223 | | |
| | _ | 31. Date filed (Month, Day, Year) 2. Registrar's Signature | | | |
| Regist | 13 | JUL 0 2 2012 Leners B. Jack | | | 1 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ PHULMATEE RAMPERSAD JUNE 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth
(Month, Day, Year)
February 4, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Hours 219-25-4133 **Director** 1 M 2 XX ary 1937 Trinidad or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Funeral Director 1 X Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 23a United States 21702 1600 Andover Lane ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ramdaye Siewlal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a 1600 Andover Lane, Frederick, MD 21702 Department of Health Important: If item 27 any injury or other the once. Harry Rampersad / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition June 26. 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Frederick, Maryland 2012 4 Donation 5 Other (Specify) 21. Signat u uneral Sovice Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 Catoctin Mountain Hwy. 9501 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t attending IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 Pregnant at time of death ed by the a detached i Yes 2 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autops 2 No this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Inpatient 2 ၉ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signatu**r** d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet 7th St. 32. R

DHMH 17 Rev 06-2011

State

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2151 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner County of Death NNE If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Funeral Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 160-20-7091 Country 87 Director 1 ፟M 2 □ F May 20, 1925 PA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maskes Evaniner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d Inside City Limits MD Anne Arundel Gambrills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 523 Watts Road 21054 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married 1 X Yes 3 Completed by 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White WWII 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Proprietor Service Station Be permit. Pege 1 end 2 should be file Department of Health and Mental H Important: If item 27 is marked on 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Rose Edith Tressler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Rose (wife) 523 Watts Rd. Gambrills, MD 21054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Vet Cem 6/18/2012 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Rd Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 500553 Medical Due to (or as a consequence of) Examine DIFICIL -605716DUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 🗆 🗤 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) G Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIOH BALDMONT ASHITOTON an Wilth 31. Date filed (Month State JUN 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:55 p M Martin Bernard Sice 2012 June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days 1 **X** M 2 □ Hours Min. 82 Yrs. Maryland 217-20-7664 1929 Nov. 6 Usual Residence of Decedent 10d. Inside City Limits 10b, County 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Port Deposit Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21904 216 Jackson Park Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates.1951-55 White 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Chrysler Corporation Elementary/Seconday (0-12) College (1-4 or 5+) Newark, Delaware Inspector Twelve Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph F. Sice Alice T. Bittner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Honeysuckle Drive, Port Deposit, Maryland 21904 (Daughter) Karen Robinson 20c. Location - City or Town, State Havre de Grace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/23/12 Mt. Erin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Maryland ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, HEFRAM 21903-0766 Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 50 PSiS disease or condition resulting in death) r as a consequence of): Due to (neumonia V a 120 Sequentially list conditions, Due to or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ✗ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation

(6) Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician for use as the burial Division of Vital Records, P.O. Box 68760 been signed by the should be detached 24 hours after death.

Funeral Director: After this certificate has page 2 funeral director, filled in by

Completed by Physician/Medical Be ၉ Certificate: Medical

Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f sidical Examiner must be notified

injury or other traumatic event, the Medical

marked other than

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Physician/

Medical

Examiner

be filed within Mental Hygiene.

death with the Maryland

Maryland 21215-0036

Baltimore,

within 2 To the F 2 11 + IVA

State Registrar

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Interna Medici ne Mchandy

6 Could not be

3 [

determined

29c. License number N66136

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 500

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Regiarar's Signature

| 17. | 050 | 99 |
|-----|-----|----|

| 12-05099 Bruce Haigler Scrog | | | oe or Print i ate of Maryla | | | | | | egible | e. | | |
|---|---|---------------------------------|--|------------------------------|---|--------------------------------|--|------------------------------------|--------------------------------|--|--|--|
| | 1- For State Registrar 1. Decedent's Nam | | | • | | of Death | | 2. Date of D | Reg. No. | 201 | 2 2243 | |
| Physician/ Medical Examiner | | | | | | | | Month July 7, 2 | Day | Year | 1053 hrs | |
| | 4a. Facility Name (2234 Autun | | n, give street and no Circle | umber) | | 4b. City, Town Gambrills | , or Location of De. | ath | | c. County of Deat Anne Arunde | | |
| Funeral Director | 5. Social Security (219-64-6 | | 6. Sex | 7. Age (In yrs. I | | If Under 1 Months I | | 1 8. Date of 1 1 2 / 27 / | , | Forei | rthplace (State or gn puntry) MD | |
| nd how any cc. | Usual Residence of 10a. State | 10b. County | Arundel | 10c. City | Town or Loc | ation Sambrill: | s | | | | 10d. Inside City Limits 1 Yes XX No | |
| the Maryland is or 28a-f show any stiffed at once. Director | | | ılley Circ | le | | 10f. Zip Cod | e 21054 | | 10g. Cit | izen of What Cou USA | intry? | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 1 Never Marri 3 Widowed | ed 2 M | arried Armed F 1 Yes Porced If Yes, Give Ye | 2XX No | | | Hispanic Origin? (ban, Mexican, Pue No specify: | | No- | 14. Race - Amer White, etc. Specify: | rican Indian, Black, White | |
| 2 hours after "natural" Examine | 15.0 | ducation (Spe | or Dates: cify only highest gra | de completed) | | | upation (Give kind of life, DO NOT use r | | 16b. | Kind of Business | Industry | |
| 5-0036 ed within 72 hour stygiene. other than "natu the Medical Exan Completed | 12 | | | | | Mechani | | | | Automot | ive | |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica for Be Comple | 17. Father's Name Todd Had | | | | | | | me (First, Middle ey Jeann | | | | |
| MD 213 d 2 should b Ith and Meni n 27 is marl | 19a. Informant's Na | ame/Relations | hip (Type, Print) | Mother | 41 | ing Address (S | treet and Number of | | umber, C | | a, Zip Code) | |
| Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 Injury or other traun | 20a. Method of Dis | position | n 3 Removal f | 20b. | Place of Disp crematory or lantic | osition (Name of other place) | cemetery, | Date / 1.1 / 2.0.1.2 | 20c. | Location - City of | ie. MD | |
| Baltil permit. Departm Importa | 21. Signature of Funeral Service Licensee 12. Name and Address of Facility Hardesty Funeral Home, P | | | | | | | | | | | |
| Physician /Medical | 23a. Part I. Enter the failure. List or | ne disease, or nly one cause | | | Do not ente | r the mode of dyi cation | ng, such as cardia complicat | c or respiratory a | diom | ock, or heart legaly | Approximate Interval Between Onset and Death | |
| Examiner | Immediate Cause or condition resulti | | | eft vent a consequence of | | r hyper | trophy | - | | | | |
| ted Insit Examiner | Sequentially list contains any, leading to in cause. Enter Under | nmediale erlying Cause | b. Due to (or as a | ā consequence o | i). | | | | | | | |
| executed an and al - transit | (Disease or injury events resulting in | | | a consequence o | of): | | | | | | | |
| 0 " | X UNPENDED | | AMENDED | 23a,27, | 28a-f, | per me,g | 929 7–27 | -12 sm | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial ledical Certification: To Be Completed by Physician/Medic. | IF FEMALE: 23b. Was decedent past 12 month 1 Yes 2 | s? | 1 Live | nant at time of de | 2 <u></u> | Fetal death Other (Specify) | 3 Ectopic pres | gnancy | 23 | ld. Date of deliver Month | y Day Year | |
| P.O. It res that the signed by the detached by by the detached by the bedeathed by Ph | | ificant condi | ions contributing t | to death but not r | esulting in the | e underlying cau | se given in Part I. | | _ | | the cause of death? bably 4 Unknown | |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rapter death. 12 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pertification: To Be | | | | | | | | | opsy formed? | prior to death? | utopsy findings available completion of cause of | |
| fital sician: is certifilirector, Be (| examiner? | | Ulassital: | Inpatient 2 | ER/Outpatie | pro-many | ace of Death (Che | | Reside | ence 6 🗸 Othe | r: Scene | |
| on of Vinding Physical Tr.: After this Tr.: After this Tr.: After this Tr.: After this Tr.: After this Tr.: After this | 1 Yes 27. Manner of Dea 1 Natural | 5 Pen | 28a. Date (Month | e of Injury h, Day,Year) | 28b. Time o | of Injury 28c. | Injury at Work? Yes 2 X No | 28d. Describ | e how inj | jury occurred | | |
| Division o to the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune edical Certification: | 2 X Accident 3 Suicide 4 Homicide | 6 Cou | ld not be 28e. Plac | ce of Injury - At h | ome, farm, st | reet, factory, offic | ce building, etc. | 28f. Location or Town Gambri | (Street a , State) 2 | and Number or R 234 Autu MD. | ural Route Number, City Imn Valley Cir | |
| To the Hosp within 24 hos To the Fune completely fi | 29a. Certifier (Check only one) 2 | | hysician: To the be miner:On the basis and manner: | of examination a | | | | and due to the ca | iuse(s) ar | nd manner as sta | | |
| A A S A S A S A S A S A S A S A S A S A | 29b. Signature and | title of certific | | | | | ense number C.M.E. | | | Date signed (Mo | onth, Day, Year) | |
| 40 | | | who completed cau D. Assistant | | | 00 W. Baltim | ore Street, Ba | ltimore, MD | 21223 | | | |
| State Registrar | | th Day, Year) |) 2012 32.R | gistrar's Signat | ure . | have | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

| | | _ For | Plea amen | se Type or d #5 per State | Prin | it in E 3929 irvland | Black In | idelible In 2012 JH artment of | i k. En Health | sure A | III Copie Mental Hy | s Are aiene | Legibl | e. | | |
|--|---|--|------------------------------------|--|--|--|---|---|----------------------------------|---|--|--|---|--|--|--|
| 1 - State Registrar | | | | | | Certificate of Death | | | | | | Reg. No. 0 1 0 0 0 1 0 1 | | | | |
| Physicia: Medic | | | | R. | | | Schaub | | | 2. Date of De | 2 30 | 2 | 3. Fime of Death 10:10 p. M. | | | |
| Examin | er | 4a. Facility Name (if Mandrin F | mber) | | | 4b. City, Town, or Location of Death Harwood | | | | 4c. County of Dea Anne | | | indel | | | |
| Funeral Director | | 5. Social Security Number 579-86-0985 Usual Residence of Decedent | | | | (In yrs. las | st birthday) Yrs. | Months Days Hours Min. | | | 8. Date of Bir (Month, Da 12/18/ | ay, Year) | | | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once. | Director | 10a. State 10b. County MD Anne Arunde1 | | | | 10c. City, | Town or Loc | mbrills | | | | | | 10d. Inside City Limits 1 ☐ Yes 2XXXNo | | |
| | Funeral Di | 10e. Street and Number 2150 Hallmark Dr. | | | | | 10f. Zip C | | | 21054 | | | tizen of What | Country | ? | |
| | ē | 11. Marital Status 1 ☑ Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decede Armed Force 12. Yes 2 Give Yes 2 Give Year or Dates | | | orces? 2 | Vic | etnam " | Vas Decedent of Yes, specify Cub | ecify Yes or No- Rican, etc.) | or No- c.) 14. Race - Am Black, Wh Specify: | | | | | | |
| | To Be Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5- | | | | +) | (Give I life. D | lent's Usual Occu kind of work done O NOT use retired | ing | 16b. Kind of Busines Union | | | stry | | | |
| | | 12 17. Father's Name (First, Middle, Last) Fred Schaub | | | | | Steam Fitter 18. Mother's Name (First, N Erna Muench | | | | | | | | | |
| | | 19a. Informant's Na | ame/Relationsh | | Mailing Address (Street and Number or Rural Route Number, Cit 37 Freemont Ct. Crofton, MD | | | | | | | | | | | |
| | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National 6/29/2012 | | | | | | | | | | 20c. Location - City or Town, State Suitland, MD | | | | |
| | | 21. Signature of Funeral Service Aicensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | | | | | | | | | | P.A. | | |
| Physician/ Medical Examiner | | 23a. Part 1. Enter to shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list control of the shock, or head in the shock | rt failure. List o (Final on | a. Due to | ach line. | conseque | Resp | the mode of dy | ing, such a | as cardiac o | or respiratory a | urrest, | ^ | | pproximate terval Between historical Death | |
| 9 7 E | dical Examiner | designation in the cause. Enter Unde Cause (Disease or that initiated event resulting in death) | erlying injury | с | | conseque | ng | Con | cer | | | | | <i>N</i> | 10 miles | |
| he death certific. y the attending p ached for use as | hysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | Fetal death 3 Ectopic pregnancy | | | | | | 23d. Date of delivery Month Day Year | | | |
| uires that t in signed b uld be deta | ficate: To Be Completed by Physician/Medica | Part II. Other signif | ficant condition | it not resu | not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | | | | |
| in: The law req ificate has bee or, page 2 sho | | 25. Was case referr | red to medical | | | | - | 00.1 | Diagonal D | | perf 1 🗆 Yes | s an opsy formed? | prior death | to comp | findings available eletion of cause of | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within Eu hours after death certificate be within Eu hours after death. To the To the Innerial Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bu | | examiner? 1 Yes 2, 27. Manner of Deat 1 Natural 2 Accident | 28a. Date (Mo. | ospital: Other: | | | | | | Check only one) ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | | | | | | |
| | Medical Certificate: | 3 Suicide 4 Homicide | build | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | City or Town, Sta | | | | | | | |
| | Medic | (Check 2 | Medical E Certifying | Nurse Practitione | asis of exa | amination | and/or invest | igation, in my opin | nion, death t the time, | occurred a date and pla | t the time, date | and place the cause | e, and due to te e(s) and mann | he cause er as stat | | |
| F 3 F 8 | - | 3QAName and addr | thel | ho completed cau | W so of do | oth (Itam) | 23a) (Timo E | | 2/ | 1430 | 5 | 10000 | te signed (Mo | 25 | 2012 | |
| HIOH Stat | e | 31. Date filed (Mont | th, Day, Year) | ENTA 1 | m | r's Signatu | 440 | 5-11-19 | lens | c /4 | wy, | , an | nnspi | elis, | Md- His | |
| Registra | | | JUN 2 | 7 2012 | Cen | wa | p. 1 | parket | | | 9 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20\2 Physician/ 730 A 1425 tewal har une Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mitchellville Villa Rosa Nursing Home Prince George's Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Hours (Month, Day, Year) 579-52-1050 1 **x** M 2 □ F Director 73 03/21/1939 Wash.,D.C. Usual Residence of Deceden show 10d. Inside City Limits or 28a-f shov notified at 10h County 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Mitchellville Md. P.G. or ? 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a filed within 72 hours after death with 20721 3800 Lottsford Vista Road U.S.A. "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2X Married 1X Yes 2 No 19760 If Yes, Give 57–60 Year or Dates. Maryland 21215-0036 Black 1 Yes 2X No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Supervisor
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Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 CC031 Signature of Funeral Service Licensee Part/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dysphace disease or condition Medical resulting in death) Examiner M Ecquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No signed by the a g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cidneu (sease 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Viseuse 24a. Was an page 2 has autopsy performed? 1 Yes 2 10 1 Yes 2 No certificate 25. Was case referred to medical examiner? Division of Vital filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury Natural s after death. 1 Yes 2 No M Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the h within 2. To the f complet only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number ene 2/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Mitchellville, Md 20721

Registrar

State

31. Date filed (Month, Day, Year)

JUN 2 0 2012

32. Registrar's Signature

| | | Plea | ase Type or | | | | | | | | | | ole. | | |
|--|--|--|--|-----------------------------------|---------------------------------|----------------------------------|---------------------|-----------------------------|-------------|--------------------------------|----------------|---|---------------------------|---------------------|--|
| | State of Maryland / Department of Health and Mental Hygiene 1 - State | | | | | | | | | | | 010 | | | |
| | | 1, Decedent's Name (First, Middle, Last) 2, Date of Death | | | | | | | | | | 3. Time | of Death | | |
| Physicia Medic | | Constance | Spence | r-R | eede | ~ | | | | June | 14 DE | y 201 | Year 5:7 | 5 A M | |
| Medic Examine | | 4a. Facility Name (if not institution | , give street and nun | nber) | | 4b. City | , Town, or | Location | of Death | | | . County of | | | |
| | | Pineview Nursin | | nton | | | | | George's | | | | | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 | | | | | | | | | , , | 9. Birthplace (State or Foreign Country) Norfolk, VA | | | |
| Director | | 223-18-3369 Usual Residence of Decedent | | 95 | | <u> </u> | | L | | 03-23- | 191/ | /1 | NOTIOIK, | OTTOIR, VA | |
| land shov d at | ģ | 10a. State 10b. County | . City, Town o | r Location | | | | | | | | City Limits | | | |
| Mary 28a-f otifie | irec | MD Prince | ort Wa | shingt | | | | | | | Yes 2 No | | | | |
| th the | <u>a</u> | 10e. Street and Number | | | | 10f. Zi | | | | _ | | nat Country? | | | |
| th wit | Funeral Director | 904 Amer Drive | 12. Was Dece | edent Ever i | alis T | 207 | | spanic Ori | igin? (Spe | cify Yes or No- | | | d States American Indian | | |
| er des or ite niner | by F | Never Married 2 Mar | 10.0. | If Yes, spe | cify Cuba | n, Mexicai | n, Puerto | Rican, etc.) | | Black, | White, etc. | | | | |
| rs afte | ed b | 3 🛮 Widowed 4 🗆 Divorced | ve ates. | 1 | 1 🗌 Yes | 2 X No | Specify. | : | | | Specify: Black | | | | |
| 2 hou "natu adical | plet | | nt's Education est grade completed, |) | (0 | ecedent's Usu Bive kind of wo | ork done d | ation <i>luring m</i> os | st of worki | ing | 16b. k | Kind of Bus | iness Industry | | |
| thin 7 ene. than he Me | Completed | Elementary/Seconday (0-12) | College (1 | I-4 or 5+) | | e. DO NOT us I cator | se retired) | | | | חר ז | Dubli. | Public School System | | |
| ed wi Hygie other ent, tl | ادہ | 17. Father's Name (First, Middle, I | | | 1 Eur | icator | | 18. Moth | er's Nam | e (First, Middle, | | | C DCHOOL | Бузсен | |
| be fil lental rked ric ev | ၉ | Thomas RichterConstance Gordon | | | | | | | | | | | | | |
| hould and M is ma | | 19a. Informant's Name/Relations | hip (Type, Print) | | 19b. N | /lailing Addres | ss (Street a | and Numb | er or Rura | Noute Numbe | er, City o | r Town, Sta | ite, Zip Code) | | |
| nd 2 s ealth m 27 ier tra | | Le'Anne Rutherf | ord/Grand | | | | | ve Fo | rt W | ashingt | | | | <u> </u> | |
| e 1 au t of H if iten | | 20a. Method of Disposition 1 Burlal 2 Cremation | 3 Removal from | n State | cemetery, | isposition (Na crematory or | other plac | | | Date | 20c. L | ocation - C | City or Town, State | , | |
| t. Pag tmen rtant: | | 4 Donation 5 Other (S | | F | t.Linco | oln Cre | | | | -2012 | | | d, MD | | |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Fundral Service | Jeensee / | 11/1 | | | | | | : Lincol Brenty | | | | | |
| | \dashv | 23a. Part 1. Enter the disease, or | r complications that | caused the | death. Do not | | | | | | | PID e | Approxi | mate | |
| Dhysisian/ | | shock, or heart failure. List of Immediate Cause (Final | | | . \ | 1 | | \ | | | | | Interval | Between nd Death | |
| Physician/ Medical | | disease or condition resulting in death) | a. Due to | (or as a con | sequence (1) | <u> de</u> 1 | NEN | DA_ | | | | | | | |
| Examiner | | O I' II I'al and I'king | | | | | | | | | | | | | |
| | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to | (or as a con | sequence of): | : | | | | | | | | | |
| executed an and rial-transit | xar | Cause (Disease or linjury that initiated events resulting in death) Last | C. Due to | for as a con | sequence of) | | | | | | | | | | |
| ria e | _ | resulting in death) Last | | (01 23 2 001 | iocquerioc oi) | | | | | | | | | | |
| cate be e physicia s the bur | Completed by Physician/Medica | | d | | | | | | | | | | | | |
| certifi inding use a | In/IN | IF FEMALE: 23b. Was decedent pregnant | 3 ☐ Ectopic pregnancy | | | | | | 23d. Date | of delivery | lelivery | | | | |
| d for | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | | gnant at time | | 5 Other (specify) | | | | | Month Day | | | Year | |
| t the c by th tache | Phys | 9 Unknown Part II. Other significant conditi | | | uk wany ikin a lin i | the underhine | , coupe air | on in Bort | -1 | OO. Did | | | | | |
| es than igned be de | by | 0 0 | | Le r | · | une underlying | cause giv | /en in Fait | | | | use contribute to the cause of death? 2 No 3 Probably 4 Unknown | | | |
| equire een s nould | etec | Jacob Catal | 21317943 | | | | | | | | | | ere autopsy findin | | |
| has b | mpl | Dyspriagi | 3 | | | | | <u> </u> | | 24a. Was auto perfe | | pr | ior to completion | | |
| n: The ficate n, pag | | 25. Was case referred to medical | | | | | 26 DI | ace of Dec | ath (Char | 1 Yes | 2 🗆 N | No 1 | Yes 2 No | | |
| rsicial s certi directo | To Be | examiner? 1 Yes 2 No | Hospital: | Innatient | 2 | atient 3 🗆 [| Othe | or. | | ome 5 Resi | dence | 6 Other | (Specify) | | |
| g Phy er this neral c | te: T | 27. Manner of Death | 28a. Date | | 28b. Tin | ne of | 28c. Injury work | y at | | 28d. Describe I | | | | | |
| endin eath. or: Aft he fur | Certificate: | | igation | riri, Day, roc | ., .,, | M | | Yes 2 |] No | | | | | | |
| or Atter fter de irecto n by t | erti | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | 28e. Place | e of Injury - A ling, etc. (Sp | At home, farm ec <i>ify)</i> | n, street, facto | ry, office | | | 28f. Location (City or Tox | | | or Rural Route No | ımber, | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu | | 29a. Certifier 1 Certifying | g Physician: To the l | host of my | nowlodes d | ath coores | at the time | data and | nless s | nd due to the | augo(c) c | nd manner | as stated | | |
| Hos 24 hc Fune eted | Medical | (Check 2 Medical | Examiner: On the ba g Nurse Practioner: | sis of exami | nation and/or i | nvestigation, in | n my opinio | on, death o | occurred a | t the time, date a | and place | e, and due t | to the cause(s) and | manner stated. | |
| Го the within Го th e | Σ | 29b. Signature and title or certifie | | . TO the best | of thy Knowled | | c. License | | o and place | oc, and due to the | | | (Month, Day, Year) | | |
| si. | | ▶ Wordelf | The state of the s | m | | 1 | 200 | 5333 | 37 | | Jui | ne 1 | 5,2012 | - | |
| 44 | | 30. Name and address of person | | | | | f | | <i>~</i> : | (| | | | | |
| ' ' | | | 24 MO | 9106 | | evien | o La | ne | (1 | nton, | 11/0 | X | | | |
| Stat Registra | | 31. Date filed (Month, Day, Year) | Deser 32. F | Registrar's S | acture | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician/ 740 AM Taahna Smith 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgonery Takoma Park Adventist Mospital Washington 8. Date of Birth (Month, Day, Year) 08/22/1983 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Country)
Washington. Months Director 577-15**-**0983 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 28a-f sho 10a. State filed within 72 hours after death with the Maryland Director DC None Washington 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20011 51 Peabody Street NE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Expone. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NONE STUDENT years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shari Liggins Floyd A. Smith, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6655 24th Place Hyattsville, MD 20782 Shari Liggins Harvey/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Metropolitan Crematory 07/02/2012 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service License 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final udden cardiac arrhythmia Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): If any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been stoned by the attendion abusinan and within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 heart Transplants 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Condio myapath autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 FA/Outpatient 3 I DOA 1 Yes Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D.o. - physician

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 8 2012

32. Registrat's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kilcle Kannowashinston Adventist Muspital, 7600 Carroll Ave, Takona Park, MD 20412

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a f Per INF G935 1/30/2013 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 25,2012 Physician/ 9:32 A M Anita M. Tyus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. (Month, Day, Country) Director 94 March 1918 Tennessee 577-60-4853 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland 10b. County Director Prince Georges 1 🛚 Yes 2 🗆 No **Hyattsville** D.C. Washington 10f. Zip Code **20782** 10e. Street and Number
4922 LaSalle Road 10g, Citizen of What Country? Funeral 72 hours after death with 20002 United States 1706 Cailes Street, North East 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 X Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ၉ Mac Fleming Emma Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12241 Bluhill Road, Silver Spring, Maryland 20902 Marvin Tyus/Son 20a, Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 07/03/2012 Brentwood, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of and that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day Pregnant at time of death cate has been signed by the page 2 should be detached g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific dempleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060100 06-25-12 TAHMINA K 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University 31 BLYD Sash 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ieroi Junte 23, Day 2012 Year osephine 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Genesis Healthcare Waldorf Center Waldorf Funeral Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**XX**F 165-20-9999 Months Days Hours Min. (Month, Day, Year) 11/24/1926 85 Director Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X X No Forestville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3809 20747 USA Forestville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 \square Never Married 2 \square Married þ Baltimore, Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2x1xx No Specify. 3 KWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) P.G. County Schools Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sobolewski Snitko Leonora Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, George Kulesza / POA 20772 15703 Nottingham Rd. Upper Marlboro, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Nat. Cem. 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Arlington, Virginia 7/24/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signate e of Funeral Service Licensee 23a. Part 1. Inter the disease, of complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. Listonly one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Infedior disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the should be detached 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 No Yes 1 🗌 Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Tyes 2 No Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month,

State Registrar

12

31. Date filed (Month, Date

lation Blud, Ste 13, Gilen Burn

Name and address of person who completed cause of death (Item 23a) (Type,

2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 4 ompson Medical 01 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AAMC Annapolis Anne Arundel Social Security Number **Funeral** If Under Year If Under 24 Hrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) 578-16-7926 Days Hours (Month, Day, Year) 91 Director 1**XX**M 2 □ F Yrs 5/25/1921 DC Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Anne Arundel Deale 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6022 Herring Bay Rd. 20751 er than "natural", or items 23st the Medical Examiner must I USA 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 XXWidowed 4 ☐ Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Thompson Ethel Mary Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Beardmore daughter 291 Deale RD. Tracy's Landing, MD 20779 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodfield Cemetery 20c. Location - City or Town, State Date Eurial 2 Cremation 3 Removal from State 6/26/2012 4 Donation 5 Other (Specify) Galesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 927 Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burialbeen signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 KIO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who comp death (Item 23a) (Type, Print) 441 LNOT

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony Joseph Trevisonno 6 1/27 / 2012 Day 6:49 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 212 Somerset St. Ocean City Worcester 6. Sex 14 M 2 D F Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) **Funeral** Days 8/31/1955 56 **Director** 213 72 0915 Usual Residence of Decedent 28a-f show 10a, State items 23a or 28a-f shorer items to be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Ocean City X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Somerset St. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white "natural", Completed 3 Widowed W Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. construction supervisor Branch Hwy. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Michael Anthony Trevisonno Catherine Zenalotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Somerset St. Ocean City, MD 21842 Department of Health Important: If item 27 any injury or other tr Lucy Ann Sydnor (Executrix) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature in Funeral Service Licensee 1st State Crematory 6/28/2012 Millsboro, DE 22. Name and Address of Facility The Burbage 108 William St. Berlin, MD Lucka 23a. Part 1. Enter the sease, or complications that case of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each pine. Immediate Cause (Final Onset and Death SCV Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed that initiated events and -tran: Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2 No been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l autopsy performed 1 Yes 2 No Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death n 24 hours after death.

Ne Funeral Director: After the pleted filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Carroll St.

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2, per phy, g929 7-17-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 6/21/2012 Month Day Year 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 4:29 Рм RICHARD VERNON WATSON MARCH 10, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death PG 2405 WHITEHALL STREET SUITLAND If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Months Days Yrs. 578-56-2808 69 03-10-1943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County PG 1 ∑Yes 2 ☐ No SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2405 WHITEHALL STREET 20746 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 21X Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH MAINTENANCE ENGINEER D.C. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THEODORE WATSON BEATRICE SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 WHITEHALL STREET, SUITLAND, MD 20747 CAROLYN WATSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SUITLAND, MD WASHINGTON NATIONAL 6-27-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licenses M00981 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) malignan UNKNOWIT Due to (or as a consequence of): Day Year e cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Funeral

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Pages 1 and 2 should be flled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner physicien and s the burial-transit

Division of Vital Records, P.O. Box 68760,

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | t. Due to (or as a consequence of): | | |
|---|---|-----------------|------------------------------|
| that initiated events resulting in death) Last | c. Due to (or as a consequence of): | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 | | 23d. Date of delive Month |
| Part II. Other significant condition | ns contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacc | co use contribute to th |
| | | 24a Was an | 24h Were autor |

To the Hospital or Attending Physician: The law requires that the death certificate be executed Completed by Physician/Medical 4 Onknown vere autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Yes 2 No death. investigation ofter death Director: / J in by the f 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 06-26-2012 125001 09 who completed cause of death (Item 23a) (Type, Print) 30. Name and address IPPMAN LARGO MO 20774 MD 9200 BASIL CT

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 2 / 201 1440 Рм Carol E. Wallin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll WestminsterMD If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours 6/15/1924 Director 412-28-6379 1 🕱 M 2 🗆 F 88 10a, State 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f sho the Medical Examinar must be notified at 10d. Inside City Limits Directo MD Carrol1 Taneytown 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4652 Babylon Rd. 21787 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 X Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 No 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates. 43 – 46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Barber <u>Barber Shop</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Page 1 and 2 should be Rankin Wallin Emma Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Betty S.Wallin - wife Babylon Rd., Tanevtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemeter, crematory or other place)
Crestlawn Memorial Gardens 7/6/12 ō 1 K Burial 2 Cremation 3 Removal from State Department Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD re of Funeral Service Licensee 22. Name and Address of Facility 34 Maple Ave. ittle's Littlestown, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EARS Immediate Cause (Final Priysician/ ATHEROSCLEROSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filed in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** e B 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify, 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDQA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospl within 24 hou To the Funer completely fil 29a. Certifier only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1-0014317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONE KINGS DRIVE TANEYTOWN MD LISTHICUM, M. D 31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature

6

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

Virginia

Gaithersburg

Month

death?

1 ☐ Yes 2 ☐ No

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Approximate Interval Between

Onset and Death

Black, White, etc.

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2012

State

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ mildred Faye Seller 3:50 PM 57 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner City, Town, or Location of Death Julia Manoa Healthcare ewter tacers town Washington 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year, 97 **Director** 1 □ M 2 💢 F 215-18-2712 June 30,1915 Maryland Usual Residence of Deceden 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Sabillas ville 1 Yes 2 No Frederick Md. 10e. Street and Number 10g. Citizen of What Country? Funeral 21780 U.S.A 14719 Foxville-Deerfield Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify 3 🗆 Widowed 4 🗆 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker n and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic once. ဂ Leacy Rea Toms Clyde Allen Buhrman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14719 Foxville-Deerfield Rd. Sabillasville, Md. 21780 Leo F. Weller (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date metery, crematory or other place)
Morian Lutheran
hurch Cemetery
22. Name and Address of Facility 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 12, Foxville, Md. 21. Signature of Funeral Service Licenses 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ a Atheroscerotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ryocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death the i g Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signer should be d 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has performed? 2 No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending s after death. 1 Yes 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npletely i within 2, To the F complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) R125360 who completed cause of death (Item 23a) (Type, Print) · 333 Mill Street, Howerstown, MD 21740

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, JUL 16

2012

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10d. Inside City Limits

Approximate Interval Between Onset an D ath

Year

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1 Yes 2 X No

9. Birthplace (State or Foreign

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USA

State Registrar 2001

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| Amend #18 per AACO Health De | | Please 6-27-12 KAH | State of M | | | | | | | _ | | _ | ible. | | |
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| Physicia | n/ | 1. Decedent's Name (First, Middle, La | , | | | | | | 2. Date of De | eath | 124 | / I be | 3. Time of | Death | |
| Medic | al | Anna Iwanna Wer | | | | | | | | June June | 2 | | Year 012 | 1:35 | A ^M |
| Examin | er | 4a. Facility Name (if not institution, given 1967 Sigfrid Con | | | | | | | apol: | | | c. County Ann | e Ar | undel | |
| Funeral Director | | 5. Social Security Number 122–26–5547 Usual Residence of Decedent | Sex 7. Agi I□M 2X2XF | e (In yrs. la: 77 | st birthday) Yrs. | Months | Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da Jan. 2 | rth ay, Yea <i>r)</i> 20, | 1935 | Cour | place (State c ntry) raine | r Foreign |
| aryland ra-f show ified at | Director | 10a. State 10b. County 10c. City, Town or Location Annapolis | | | | | | | | 10d. Insi | | | ty Limits | | |
| with the M 23a or 28 ust be not | Funeral Dir | 10e. Street and Number 1967 Sigfrid Co | ırt | <u> </u> | | 10f. Zij | p Code | 2140 | 1 | | 10g. C | g. Citizen of What Country? U.S.A. | | | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 ☐ Never Married 2 ※Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates. | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2凇No Specify: | | | | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Exami | Completed | 15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) | rade completed) College (1-4 or 5 | 5+) | | aind of wo O NOT use | ork done c e retired) | luring most | of workir | 16b. Kind of Busines | | | | · | |
| 2 21 ad with Hygier int, the | Be C | 17. Father's Name (First, Middle, Last) | | HC HC | | | | | | | <u> </u> | | n Ho | me | |
| lance be file lental l rked o | To E | Iwan Hodowanec | | | | | | P. Mothe | Shve | (First, Middle, Edink Pa | | oen sumame) Iskeviya Shvedink | | | |
| , Mary d 2 should alth and N n 27 is ma er treumat | | 19a. Informant's Name/Relationship (Wolodymyr Werchr | Type, Print) niak/spouse | 9 | 19b. Mailin 1967 | g Address Sig | s (Street a | and Numbe Court | r or Rural | Route Numbe | er, City o | ; City or Town, State, Zip Code) 5, Maryland 21401 | | | |
| Baltimore, bernit. Page 1 and bepartment of Hea mportant: If item any injury or other ance. | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | Removal from State | ce | ace of Dispos metery, crem LIMORE | atory or c | other place | e) Cy 6 | | ate /2012 | | | - | own, State Maryla | nd |
| Balti permit. Departr Import any inji | | 21. Signature of Funeral Service Licen | Colrect | | | | | | | n M. T | | | | | |
| Physician/ | | 23a. Part 1. Enter the disease, or comshock, or heart failure. List only disease or condition resulting in death) | a. HYPUR | ביקפוני | sive | | | g, such as d | | _ | rest, | | | Approximate Interval Betwoest and Conset and | ween |
| Examiner | _ | Sequentially list conditions, | Due to (or as a | a conseque | ence of): | | | | | | | | | | |
| executed en and rrial-transit | Examiner | If any, leading to first redicte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): | | | | | | | | | - 21 | | | | |
| 9 9 5 | = 1 | | | | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the burn | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown | 1 Live Birth | outcome of pregnancy ve Birth 2 Fetal death 3 Ectopic pregnancy regnant at time of death 5 Other (specify) | | | | | | | | 23d. Date of delivery Month Day Year | | | 'ear |
| IS, P.C. | ρ | Part II. Other significant conditions of | | _ | | | cause giv | en in Part I. | | | | | | ne cause of de | |
| Division of Vital Records, P.O. all or Attending Physician: The law requires that the safter death. In Director. After this certificate has been signed by ed in by the funeral director, page 2 should be detactor. | Completed | WIRAL | RETUR | -OZ TY | TOW | <u>)</u> | | | | | psy ormed? | pr de | ior to co | osy findings a | vailable ause of |
| ital Residian: The certificate rector, pag | BeC | 25. Was case referred to medical examiner? | | | | | 26. Pla | ace of Deati | h (Check | 1 | 2 1 | 0 1 | ∐ Yes | 2 X No | |
| f Vit | 욘 | 1 🗆 Yes 2 🕽 📢 o | | | R/Outpatient | 3 □ D | OA Othe | er: 4 🗌 Nui | rsing Hon | ne 5 Resid | dence (| 6 ☐ Other | (Specify |) | |
| ion of ending F eath. or: After i | Certificate: | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | | ry 2 , Year) | 8b. Time of injury | M 2 | 28c. Injury work 1 🔲 | | | 8d. Describe h | now injur | ry occurred | i | | |
| Division Atture de la Directe de la Directe | | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, Stat | | | | | | | ın, State | e) | | | er, | | |
| the Hosp hin 24 hou the Funel mpletely fi | Medical | only one 3 Certifying Nur | sician: To the best of iner: On the basis of exse Practitioner: To the | kamination a | and/or investi | gation, in I | my opinio | n, death occ | curred at t | he time, date a | and place | e, and due t | to the cau | use(s) and mar | nner stated. |
| P in P in S | | 29b. Signature and title of certifier | Gravell | 0 | | 29c | License | number 4 | + | | 29d. Da | signed 25 | Month, l | Day, Year) | |
| 4, | | LODEK K BE | Completed cause of de | 3 M | edi W | int) | PKU | M 2 | JD | Ann | 26 n | W | Ш | 12,40 | الزد |
| Stat Registra | e r | 31. Date filed (Month, Day, Year) JUN 2 7 2 | 012 32. Registra | r's Signatur | d. S. | ale | , | | | | | | | | - |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert M. Webster 2012 10:30 P M 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months Hours 02/18/1914 Director 98 214-18-4247 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st e notified a 1 ☐ Yes 2X No St. Mary's Maryland Charlotte Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral . Page 1 and 2 should be filed within 72 hours after death with irrnert of Heath and Mental Hygiene. The must if them 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Examiner must b 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Archie Webster Florence Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Donner / Granddaughter 11940 Six Gun Circle Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If if any injury or o cemetery, crematory or other plan Brinsfield-Echols Crematory 1 Burial 2 X Cremation 3 Removal from State 06/23/2012 |Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SQUAMOUS LECE (ARCIULOMA F disease or condition resulting in death) 17 mos Medical to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or linjury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medic examiner? funeral director, 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No iniury 1 Natural 5 Pending ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signet 29c. License number 29d. Date signed (Month. Day. Year)

State

DHMH 17 Rev 7/2009

Registrar

ompleted cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Steven G. White 2012 10:10am Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours (Month, Day, Year) 066-44-7534 1 X M 2 □ F Yrs 60 Usual Residence of Decedent 11/06/1951 New York 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Montgomery Maryland Silver Spring 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12325 New Hampshire Avenue 20904 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give q 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify. Year or Dates. Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Women's Apparel Retail & Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert H. White Franszika Fürst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter A. White - Brother 19 Muzeum Korut, Budapest, Hungary 1053 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns 06/19/2012 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Maris Como 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 2 Weeks Endocarditis disease or condition resulting in death) Due to (or as a consequence of). End Stage Renal Disease Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Permacath Catheter Infection, Severe Systolic 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Dysfunction, Cardiomyopathy, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner burial-transit and attending physician requires that the death certificate be Box 68760 as the l use ned by the atten edetached for u Division of Vital Records, P.O. the Hospital or Attending Physician: The law in 24 hours after death.
Into 24 hours after death.
The Funeral Director, After this certificate has be the prepared in the funeral director, page 2 s mpletely filled in by the funeral director, page 2 s

Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.

Pnysician/

Medical

Physician/Medical

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Completed

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Certificate:

Medical

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shyamsundar,

M.D.

istrar's Signature

only one

Rajan. Date filed (Month.)

Baltimore, Maryland 21215-0036

must be notified at

with the Maryland

28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

D53367

1500 Forest Glen Road, Silver Spring, Maryland 20910

June 16, 2012

To the within 2

DHMH 17 Rev 06-2011

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Juanita Foster Walker 19 2012 10:58 P.[™] June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Nursing & Rehab. Center Clinton Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min Hours Jacksonville, 265-20-7015 **Director** 88 1 M 2 X F 01/03/1924 Florida Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 3a or 28a-f sl P.G. Upper Marlboro 1 X Yes 2 No Md. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 14512 Brock Hall Drive 20772 U.S.A. "natural", or items 23 edical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 10 · 1 Never Married 2 Married þ 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. vears Safeway Food Stores <u>Warehouse Worker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Nathaniel Walker Lillie Mae Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2...
Department of Health an Important: If item 27 is Angela L. Weaver/Daughter 14512 Brock Hall Dr., Upper Marlboro, Md. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 06/27/12 Landover, Maryland 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licensee Loule CC0310 sauce 4925 Burroughs Ave N.E. Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ O Condal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 6/20 away 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Branch Avenue Clinton KHOSTOW Davachi 7801 010 Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death Physician/ Charles E. Becker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKLIN SQUARE ROSEDALE HOSPITA 8. Date of Birth 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Social Security Number **Funeral** (Month, Day, Year) June 25, 192 180-20-5953 85 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director Middle River MD Baltimore 10e. Street and Number 10f. Zip Code 21220 Funeral 5708 Hilltop Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crane Operator (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Long 2 Ralph Becker injury or other traumatic BECKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 14415 Cuba Road Hunt Valley MD 21030 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Charleenia Becker /daughter 20b. Place of Disposition (Name of 7/20/12 20a. Method of Disposition HappyVaTTeyMemorial ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE Physician/ disease or condition resulting in death) MYOCARDIAL INFARCTION Medical Due to (or as a consequence Examiner Sequentially list nonditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of CONGESTIVE attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 687601 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Pregnant at time of death Other (specify) signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, Completed peen 24a. Was an cate has I autopsy performed? this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tyes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: Manner of Death 28d. Describe how injury occurred 28c. Injury at hours after death. Ineral Director: After work? 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier Lecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatuj 29c. License number RES 0000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEDI

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Registrar's Signature

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 4c. County of Death BALTIMOR 9. Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 Yes 2 XNo 10g. Citizen of What Country? USA 14. Race - American Indian Black White etc White 16b. Kind of Business/Industry Armco Steel 20c. Location - City or Town, State
JohnsonCity TEnn. 300 Mace Ave. Balto. MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month. Day, Year)

State Registrar FRANKLIN SQUACE DRIVE BALTIMORE, MD.

Burden, Anguelink

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| | | 1 | For State Registrar | otate of Maryland / t | Certificate of I | | , , | Reg. No. 2 | 12 2211 |
| Phys | cian | | 1. Decedent's Name (First, Middle, Last) | 17 / | | | 2. Date of Dear | th | 3. Time of Death |
| Me | dica | 4 | la. Facility Name (if not institution, give street | Burden | 4h City Tours | v I as ation of Death | JÜĽY | | 012 07:43Ам |
| Exal | nine | | | 100 | | r Location of Death | | 4c. County of BA | LTIMORE |
| Fune Direct | _ | 1 | 3. Social Security Number 6. Sex 214-50-1914 1 □ N | 7. Age (In yrs. last birth | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | Birthplace (State or Foreign Country) |
| 3 | | | Usual Residence of Decedent 0a. State 10b. County | 62 | Yrs. | | 1-6-1 | 950 | MD |
| Maryland 28a-f sh | Emeral Director | 0100 | md Baltima | () | da 1/5 town | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| hthe M aor28 benot | غُ ا | <u> </u> | 0e. Street and Number | , Turio | 10f. Zip Code | | | 10g. Citizen of Wha | |
| death with titems 23a | i | nue | 4318 Hanwe/ 1. Marital Status 12. | Was Decedent Ever in U.S. | 13. Was Decedent of H | 91133 | cify Ves or No- | U- | 5/4 |
| 36 fter der ', or ite | 3 | 2 | 1 Never Married 2 Married | Armed Forces? 1 Yes 2 No If Yes, Give | If Yes, specify Cuba | an, Mexican, Puerto | Rican, etc.) | Black, \ | American Indian, White, etc. |
| 5-003 2 hours aft "natural", | poto | nala | 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educa | Year or Dates. | Decedent's Usual Occup | | | Specify: | Slack |
| 215 Din 72 the Be. Chan "n | Completed | | (Specify only highest grade of | | (Give kind of work done of life. DO NOT use retired) | durina most of worki | ng | 16b. Kind of Busin | - 1 |
| nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene 4 other then "natural", or items 23a or 28a-f sho vent, the Medical Examiner musts be notified at | Bo | b | 7. Father's Name (First, Middle, Last) | | hild Care | 18. Mother's Name | (First Middle A | St. Jero | mes Church |
| i ke ent | F | 2 | Jesse McKn | ight | | France | - | 10/5 | |
| Mary 2 should th and M 27 is mar traumat | | | 19a. Informant's Name/Relationship (Type, I | /λ // 19b. | Mailing Address (Street | and Number or Rura | Route Number, | City or Town, State | |
| 1 and 1 and 3 Healt item 2 other | | 2 | 0a. Method of Disposition | | Disposition (Name of | Jell Road | - | 20c. Location - Cit | m) 21133 by or Town, State |
| Baltimore, N permit. Page 1 and 2. Department of Health Important: If item 27. any injury or other tr | | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) | noval from State Garr | y, crematory or other place | £ 1-20 | 5-2013 | DWING | |
| Balti permit. Departr Importa | ouce. | 1 | 21. Signature of Funeral Service Licensee | L. | 22. Name and Address | ss of Facility \au | ghn C. A | / / | neral Services MD 21133 |
| | | \dagger | 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca | ions that caused the death. Do no | ot enter the mode of dyin | g, such as cardiac o | r respiratory arre | | Approximate Interval Between |
| Physicia Medic | | - 1 | Immediate Cause (Final disease or condition resulting in death) | pulmonar | y fibrosis | | | | Onset and Death |
| Examin | er | | ſ | Due to (or as a consequence of the sound specific sounds) | c interst | tial pr | eumoi | 110 | |
| sit of | Examiner | | of any, leading to immediate cause. Enter Underlying | Due to (or as a onsequence of | f): | | (Wijiio) | , , , , , | 1 |
| xecute n and al-tran | Exar | | Cause (Disease or injury that initiated events c. = resulting in death) Last | Due to (or as a consequence o | f): | | | | 1 |
| ox 68760 eath certificate be executed attending physician and I for use as the burial-transit | dical | | d | | | | | | |
| 68760 certificate be nding physici use as the bu | Completed by Physician/Medical | | F FEMALE: 23c. | If yes, outcome of pregnancy | | | | 23d. Date o | fdalivan |
| Box death contract the attented for up | sicia | | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 Ectopic pregnand 5 Other (specify) | Sy . | | Month | Day Year |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate 40 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use | Phy Phy | | 9 ☐ Unknown Part II. Other significant conditions contrib | | the underlying cause giv | ven in Part I. | 23e. Did tob | pacco use contribut | te to the cause of death? |
| ds, F quires t en sign ould be | d be | | acute n | enal failure | 2 | | 1 □ Y€ | es 2 🗆 No 3 🛭 | Probably 4 Unknown |
| Division of Vital Records, all or attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be | mple | - | | | | | 24a. Was ar autops | y prior | e autopsy findings available to completion of cause of |
| al Re an: The tifficate tor, pag | Be Co | 2 | 5. Was case referred to medical | | 26 PI | ace of Death (Check | | ned2 deat | Yes 2 No |
| Vita hysicia his cer | <u> </u> 2 | 2 | examiner? 1 \(\sum \) Yes 2 \(\overline{\text{No}} \) No | 1 mpatient 2 ER/Out | patient 3 DOA Othe | ar. | | ince 6 Other (S | pecify) |
| in of iding P th. After the funers | cate: | 2 | 1 Natural 5 ☐ Pending | 28a. Date of injury (Month, Day, Year) 28b. Ti | jury work | / at ? Yes 2 □ No | 8d. Describe ho | w injury occurred | |
| r Attenter dear | Certificate: | | 3 Suicide 6 Could not be | 8e. Place of Injury - At home, far building, etc. (Specify) | | | | | Rural Route Number, |
| Div pital or burs aff eral Dir filled ir | | | 9a. Certifier 1 Certifying Physician | : To the best of my knowledge, o | | 4 | City or Town | , | |
| he Hos in 24 h he Fun ipletely | Medical | ĺ | (Check 2 \(\sum \) Medical Examiner: | On the basis of examination and/or actitioner: To the bast of my know | investigation, in my opinic | on, death occurred at | the time, date and | d place, and due to | the cause(s) and manner stated. |
| To the with To the Common | | | 9b. Signature and title of certifier | 000 | 29c. License | number | 2: | 9d. Date signed (M | gnth, Day, Year) |
| (0 Wr | | 3 | D. Name and address of person who compl | eted_cause of death (Item 23a) (T | ype, Print) | 135000 | <u> </u> | 1/17/ | 21204 |
| <u> </u> | | | Mark Gosnell | 6535 N.C/ | harles, Su | ite 550 | N. Fai | villion | Towson, MD |
| S Regis | tate trar | 3 | i. Date filed (Ivionith, Day, Year) | 32 Registrar's Signature | back | | | | · |
| DHMH 17 Bey I | 16-201 | 1 | JUL 1 / 2012 | Marie Print | 6 | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 12, 2012 Ursula Bolduc 2:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Upper Marlboro 4606 Mimsey Road Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 554 54 8906 Director 86 1 □ M 2 🗓 F April 8, 1926 Germany 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ms 23a or 28a-f s must be notified 1 Yes 2 XXVo Maryland 1 4 1 Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 4606 Minsey Road 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married e X No 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ano cof Health and them 27 is marn. 2 Johann Hepp Elizabeth Kolter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis P. Bolduc 4606 Mimsey Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) MD Veteran's Cemetery Cheltenham, MD July 23, 2012 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Clinton, MD Ferry Road. 20735 a 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Certificate: To Be Completed by Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Pregnant
☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypothyrovalism Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural
Accident 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Comprise Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one who completed cause of death (Item 23a) (Type, Print) hoad 900 E. Swam Creek

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2012 Physician/ July 9:12 PM Alfred L. Brennan, Sr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 212-26-5001 Director 1 XM 2 □ F 83 Yrs. Dec. 10, 1928 Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12251 Roundwood Road, Unit 802 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 M Married þ 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore County Retired Judge Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick D. Brennan, Sr. Elizabeth McConneghey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Brennan/Wife 12251 Roundwood Road, Unit 802 Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 2012 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Femeral Service Dicensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Inc. Flagle emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1 Enter the dis shock, or heart failure. Lis Approximate Interval Between Immediate Cause (Final Onset and Death 300 Physician/ has cances disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence Se Other (Specify) V Certificate: To 1 🗌 Yes No No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) nd title of certifie ddress of person who completed cause of death (Item 23a) (Type, Print) M 31. Date filed (M 2. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| etty Delschile | | 1- For State Registrar | or Maryland / D | • | te of Deati | | | Reg. No. | 012 224 | 1 | | |
|---|----------------|---|--|------------------|---------------------------------------|---------------------|---|-----------------------|--|----------------------|--|--|
| Physic | | Decedent's Name (First, Middle, La | est) | | | | 2. Date of De Month | | 3. Time of Death | | | |
| fedical Exam | iner | _ DCCCy DCICCO DCIDO | | | | | July 12, 2 | 2012 | 1128 nrs | | | |
| | | 4a. Facility Name (if not institution, g 3754 Hickory Avenue | ve street and number) | | 4b. City, 1 Baltim | own, or Location | of Death re County | | | | | |
| Funeral | | Social Security Number 6. 9 | Sex 7. Age (In | yrs. last birthe | | | er 24Hrs. 8. Date of B | | Y) 9. Birthplace (State or | _ | | |
| Director | | 212-20-2843 1 [Usual Residence of Decedent | м 2XX 84 | + | Yrs. Months | Days Hour | s ^{Min.} Februar | y 19,1928 | Foreign CountryMaryland | | | |
| any | | 10a. State 10b. County | 10c. | City, Town or | Location | _ | | | 10d. Inside City Lim | its | | |
| Maryland 28a-f show d at once. | 5 | Maryland — | | Bal. | timore | | | | 1)(X)(Yes 2 | 1XX Yes 2 No | | |
| he Maryl or 28a-i | Director | 10e. Street and Number 3754 Hickory Ave | | | 10f. Zip | Code L211 | | 10g. Citizen of WI | The state of the s | | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygiens Important: If tiens 73 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Modical Examiner must be notified at once. | Funeral | 11. Marital Status 1 Never Married 2 Marrie | 12. Was Decedent Ever | | | | gin? (Specify Yes or N n, Puerto Rican, etc.) | | e - American Indian, Black, e, etc. | rican Indian, Black, | | |
| fter de I", or i | | 3√√ Widowed 4 Divorce | 1 Yes 2XX | No | 1 Yes 🟌 | No specify | : | Specify.\(\) | √hite | | | |
| oours a natura 'xamir | ed by | 15. Decedent's Education (Specify of | only highest grade complete | ed) 16a. De | ecedent's Usual (| - | kind of work done | | b. Kind of Business/Industry | | | |
| 36 nin 72 h e. Chan "t | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | | HOmemak | _ | doc rolling. | Own | Home | | | |
| 5-00 ed with lygiene other | Com | 17. Father's Name (First, Middle, Las | t) | | | 18.Mothe | r's Name (First, Middle, | Maiden Surname |)) | _ | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | Be | Tom Ensor | | | | | sie Fletcher | | | _ | | |
| MD 2. d 2 should the and M as 27 is m. | 욘 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Pouglas Keithley/ Nephew 1917 Thomas Run Road, Bel Air Maryland 21015 | | | | | | | | | | |
| Ore, ges l and of Heali if item | | 20a. Method of Disposition 1 XX Burial 2 Cremation 3 | Removal from State | cremator | Disposition (Nam y or other place) | • | Date | 1 | - City or Town, State | | | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr | | Falls Road UM Cemetery July 18, 2012 Reisterstown 1/2 Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee Licensee 22. Name and Address of Facility Burgee Licensee | | | | | | | | | | |
| Depi | | Carol May S 3631 Falls Road, Baltimore, Maryland 21211 | | | | | | | | | | |
| Physician Medical | | 23a. Part I. Enter the disease, of comfailure. List only one cause on e | ach line. | | | dying, such as o | ardiac or respiratory ar | rest, shock, or hea | Between Onset an | | | |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | Chronic Obstructive | | y Disease | | | | Death | | | |
| | | Sequentially list conditions, | | | | | | | | | | |
| | nine | if any, leading to immediate cauce. Enter Underlying Cauce (Disease or injury that initiated | Due to (or as a consequer | nce of): | | | | | | | | |
| ecuted and transit | Examiner | events resulting in death) Last | Due to (or as a consequer | nce of): | | | | | | | | |
| 60, ate be execut hysician and te burial - tra | Medical | UNPENDED | AMENDED | | | | | | | | | |
| 8760, ifficate be ng physici | | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, outcome of | pregnancy 2 | Fetal death | 3 Ectopie | c pregnancy | 23d. Date of Month | delivery Day Year | | | |
| Box 687(ne death certifica the attending pl | Physician/ | past 12 months? 1 Yes 2 No 9 Unknow | 4 Pregnant at time | | Other (Spec | | | Silve Market | July 10u. | | | |
| O. B. at the de by the | | Part II. Other significant conditions | 9 Ouknown | not resulting in | n the underlying | cause given in Pa | art I. 23e. Did t | obacco use contri | ibute to the cause of death? | _ | | |
| P.O. | d b | Fractured Left Femur | | | | | 1 Ye | s 2 🗸 No 3 | Probably 4 Unknown | 1 | | |
| ords w requi | Completed | | | | | | 24a. Was autor | | Were autopsy findings availab prior to completion of cause of | | | |
| Reco The law cate has | mo | | | | <u>-</u> | | | rmed? d 2 ✓ No 1 | death? Yes 2 No | | | |
| tal Rec | B. | 25. Was case referred to medical examiner? | Hospital: | | | 1Othor C | (Check only one) | | | | | |
| of Vi ing Physi After this uneral dir | 은 | 1 Yes 2 No 27. Manner of Death | Hospital: 1 Inpatient 2 | | ne of Injury 2 | Bc. Injury at Work | Nursing Home 5 28d. Describe | Residence 6 v | | _ | | |
| On C cending sath. or: Af | tion | 1 Natural 5 Pending | Jul 11, 2012 | 2030 1 | | 1 Yes 2 ✓ | Subject fell | , | | | | |
| Division of Vital Records, to a Attending Physician: The law require attendenth. al Director, After this certificate has been sited in by the funeral director, page 2 should be | Certification: | 2 Accident Investigat 3 Suicide 6 Could not determine | be 28e. Place of Injury - | | | office building, et | or Town, S | State) | er or Rural Route Number, Cit | ly | | |
| Di Hospital 4 hours a Puncral I | | 29a. Certifier | (Specify) Single | | | ime date and pla | A / | Avenue, Baltim | | -10 | | |
| Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans | Medical | one) 2 Medical Examine | r:On the basis of examinat and manner stated. | _ | estigation, in my | opinion, death oc | | and place, and di | ue to the cause(s) | | | |
| | Ž | 29b. Signature and title of certifier | \sim | | | O.C.M.E. | | | ed (Month, Day, Year) | | | |
| | | (latelle M | () | (Itom 22a) | | ∪.∪.IVI.⊏. | | July 13, 20 | 12 | | | |
| h | | Name and address of person who Laron Locke MD. Assis | tant Medical Examin | | V. Baltimore | Street, Baltin | nore, MD 21223 | | | | | |
| | 1011 | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | | | | | | | | | |
| Regis | trair | <u> </u> | A men | 1 136 | Keel | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death Physician/ 81 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Cont Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year **Funeral** Days **Director** 212-52-7017 1 □ M 2 🛣 F 63 Virginia Apr 11, 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 311 Walgrove Road 21136 U.S.A. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 5 Completed by 1 Never Married 2 🙀 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced Specify: Year or Dates White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Horsemans Association <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of marked c ည Richard E. Elizabeth M. Camden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela D. Ford Sister in Law 1800 Camargo Drive Westminster, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 7/17/12 Hampstead, MD ure of Fun 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ WITH METAS disease or condition UTERINT Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician a the burial Physician/Medical P.O. Box 68760 as 1 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy MELLITIE performed? death? Hospital or Attending Physician: The certificate 1 Yes 2 No Division of Vital 25. Was case referred to medies Be 26. Place of Death (Check only one) examiner? 1 Yes ည 1 I Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month Wilbur James Baughan 2012 8:30 QM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Roseda Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 214 14 3503 89 Director 1 🖾 M 2 🗆 F Aug. 22, 1922 Maryland Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 3526 Dahlia Lane 21220 USA Baughan, Wilbu 12. Was Decedent Ever in U.S. Armed Forces?

1 May Yes 2 No If Yes, Give 1943/45 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Accountant Utility Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk. Baughan Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Helen Shouman (Friend) 1216 West Lake Avenue Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 7/18/2012 Garrison Forest, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex. Maryland 21221 23a. Roft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Due to (or a a consequence of): Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Renal failure Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 No death? dosis or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔽 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) To Hauti's JULY, 14/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Kottarathi) 9000 Franklin Square Drive, Baltimore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ Cecilia Franques Dorothy Bordelon 2012 3:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 435-70-4230 Director 1 □ M 2 🕅 E June 9, 1919 93 Louisiana Usual Residence of Decede show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 X Yes 2 No Louisiana St. Landry Opelousas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 431 South Court Street 70570 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Midowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher / Homemaker Schools Own Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bernard Baldwin Franques Eunice Dejean permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice Jane Bordelon Berteau/Daughter 6900 Horizon Terrace, Derwood, Maryland 20855 Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State July Bellevue Memorial Opelousas, Louisiana 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Furieral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01035 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastrointestinal Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burlal-transi death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🛣 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) nours after death. neral Director: After the filled in by the funera 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours af To the Funeral Discompletely filled in Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063195 July 14, 2012 رو) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Steven Wilks, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker JUL 1 7 2012 Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend # 10e&f &30 Per FH G929 7/17/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BRUNEAU Medical clity Name (if not in titution, give street and number) **Examiner** 4c. County of Death 110 8. Date of Birth
Month, Day, Y last hirthday **Funeral** (In vrs If Under 9. Birthplace (State or Foreign Year) 923 1 M 2 F Months Hours Min. Director Country) Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MI altimore 1 Nes 2 □ No 10e. Street and Number ò 10f. Zip Code 21211 2095 10g. Citizen of What Country? Rockrose Ave Funeral 23a items ? within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 2 1 Baltimore, Maryland 21215-0036 Yes permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) +ccounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 runeau traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E altimore Honore injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any inj 21. Sign Jury of Funeral Service Licensee 22. Name and Address of Facility Howe 234. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death DEMENTI SSIVE DRO GE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ADR716 ANEUCYSM Hospital or Attending Physician: The law requires that the death certificate be executed DRACIC Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? ō 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed Yes 2 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural iniury work? 1 ☐ Yes 2 ☐ No the f Accident Investigation 3 Suicide
4 Homicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one 29b. Signature and title of certiflet 29c. License nur 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Baltimore, MD21215 MITSAN 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Physician/ 1EW Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death 1611 Wentworth Ave Baltimore Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 217-34-3336 Months Davs Hours Min. (Month, Day, Year) Director 1 № M 2 🗆 F 74 Yrs Feb.22,1938 VA Usual Residence of Decedent show 10a, State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 Wentworth Ave. Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married ty Yes 2 No if Yes, Give NAVY Year or Dates. þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 √2 No Specify: 3 Widowed 4 Divorced Completed Specify:Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Robins Transport 12th Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file | Mental | should be file n and Mental h is marked o ည Matthew Bailey, Sr. Beulah O. Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marguerite C. Bailey (wife) 1611 Wentworth Ave.Balto,Md.21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest July24,2012 OwingsMIlls, Md. 21. Surfure Uneral Service Licen 22 Name and Address of Facility Calvin B. Scruggs Funeral Home Md. 21213 Preston St. Bal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any leading to immediate cause Filter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number Name and address of person who completed cause of death (Item 23a) 693 ed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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State of Maryland 7 Department of Health and Mental Hygiene For State Registrar - State
Registrar

1. Decedent's Name (First, Middle, Last)
Beunett Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ 2012 40 AM Medical institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ORIEN Rehab 6334 Cedarlane Howa unba **Funeral** 7. Age (In yrs. last birthday Year If Under 24 Hrs. 9 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Months Min. Hours Director 01/03/1923 Country) 089-12-7967 NY Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified MD HOWARD COLUMBIA 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral 7110 MINSTREL WAY 21045 USA . Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
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Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) ISRAEL CEMETERY 07/15/2012 WOODBRIDGE, NJ ure Funeral Service Lic nse 21. Signi 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Month Pregnant at time of death Day Year the should be detached 9 Unknow Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autop perform autopsy 24 hours after death.

Funeral Director: After this certificate 2 🗌 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No the f Accident Investigation M 3 Suicide 4 Homicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lorien Rehab Columbia, Md. Michelle Klima 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ 8:50 AM REBECCA DICHTER BRILLIANT 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TUDOR HEIGHTS SENIOR LIVING BALTIMORE N/A Social Security Number **Funeral** 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Min. Hours (Month, Day, Year) 01/05/1917 Country) **Director** 219-32-3860 95 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Ty Yes 2 No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 7218 PARK HEIGHTS AVENUE 21208 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. 3 🗓 Widowed 4 □ Divorced Completed Year or Dates WHITE d 2 should be filed within 72 hours alth and Mental Hygiene.

127 is marked other than "natura er traumatic event, the Medical E. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **ABRAHAM** DICHTER ROSE KORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai ARLENE OGURICK/NIECE 333 E. 30TH STREET, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MIKRO KODESH BETH 4 ☐ Donation 5 ☐ Other (Specify) 07/15/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_si_ian ACCIDENT CEREBRUVASCULAR months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Exami death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death the 9 Unknown g Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à CArdIO VASCULAR DEVUENTIA Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 14 pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has h page performed? Yes 2 N DIABETES MELLITUS certificate 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျ ASSISTED 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident 1 Yes 2 No I Director; A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ROBERT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nun

6503

M. COOPER

JUL 1 7 2012

PARK

03037

HEIGHTS AVE

29d. Date signed (Month, Day, Year)

BALT MID

12

REPLACEMENT Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1651 Kegina Bradley 2012 Α. 01 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Univ. Of Maryland Med. Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗗 F 48 222.52-8643 05/30/1964 Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Modical Examinar count to notified at 1 Yes 2 No Kent DE Completed by Funeral Director Dover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 19904 Street 611 wit. Peges 1 and 2 should be filed within 72 hours after death ariment of Health and Mental Hygiene.
orient: If them 27 is marked other than "natural", or Items 23s njury or other traumatic event, the Medical Example result. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 7 No Maryland 21215-0036 1 ☐ Yes 2 INo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nancy Moore David ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street. west Delaware Dover. Robert Bradley - husban Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State permit. Pege Department o Importent: If any njury or Dover, Delaware Capital Crematory 7/13/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 615, Bradford ST DO SOV DE 19904 gula Carlou V TORBERS FULLYAL CHAPEL DO JOY DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure Physician Min cardiac dul /Medical Due to (or as a consequence of): **Examiner** piopotoi musion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Septic SMOCK weeks Due to (or as a consequence of): P.O. Box 68760, pheumoura Week as the l for use a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by should be 3 Probably 4 Unknown latory-dependent respiratory farture 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy synchome respiratory distresi 1 ☐ Yes 212 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 🗌 Yes 24 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and integor certifier 9464829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Baltimore Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 14 Day Paul Marsden Cubeta 2012 7:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing & Rehab. Bethesda Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Days Hours Director 049-14-9682 1 🛛 M 2 🗆 F 87 Mar. 12, 1925 Connecticut Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director DC: Washington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2737 Devonshire Place, NW 20008 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married 1 X Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Caucasian 3 X Widowed 4 Divorced Completed Year or Dates. 42–1945 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Education College Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Salvatore Cubeta Marion Bacon of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Phillip Cubeta / son 270 South Bryn Mawr Ave. Bryn Mawr, PA 19010 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o nent of 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Final Journey Crematorly 7/17/12 Woodbine, MD permit. 21. Signature of the neral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Aspiration Pneumonia Medical resulting in death) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Late effects Cerebral Vascular Accident burial-tran that initiated events resulting in death) Last Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Year Pregnant at time of death igned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed Aortic Stenosis, Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform MARSDEN Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 2 Accident
3 Suic 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director; A
d in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c, License number 29d. Date signed (Month, Day, Year) 2012 07/16 D35579 Pr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8212 Wisconsin Ave. Bethesda, MD 20814 Susan Miller, 31. Date filed (Month, Day, Year Registrar's Signature Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death awman , Sr. Physician/ : 56AM July 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1890 Church Road Dunda1k Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 XM 2 □ F Hours 80 July 12 1932 Maryland Director 213-30-1860 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 ☐ Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1890 Church Road 21222 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1950If Yes, Give 1002 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced 1982 Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) State Highway Admin. Data Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Herbert Cowman Mary Frances Serio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Brzezenski/daughter 1890 Church Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 7/14/2012 Baltimore, Maryland Signature of Fungral Service Licensee Stephanie 22. Name and Address of Facility Cremation Society of Maryland Inc. 299 Frederick Road baltimore, Maryland 21228 Custer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final hageaL Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of çertifier 10 2/ Registrar

State of Maryland / Department of Health and Mental Hygiene Angel Jovani Ayala-Cerros Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 2. Date of Deeth 3. Time of Death Month Day Year Examiner 1905 hrs ANGEL GIOVANI July 1, 2012 AYALA CERROS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Bay near buoy #81A Chesapeake Beach Calvert **Funeral** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Dete of Birth (MM/DD/YYYY 9. Birthplece (State or Foreign Days Country) AGILARES Months Hours Min Director 730-01-0383 1 XM 2 F 27 11-1-1984 SALVADOR Usual Residence of Decedent 10a, State 10h. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No ral", or items 23a or 28a-f show ALEXANDRIA pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, if a Market I have been more he morited. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7852 EAGLE AVE 22306 큠 EL SALVADOR Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11 Manifal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married Yes 2 X No EL 1 Yes 2 No specify: SALVADORIAN Specify: HISPANIC 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12TH PIPELAYER PRIVATE 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) JESUS AYALA HENRIQUEZ MIRIAN AMAYA Be 19a. Informant's Name/Relationship (Type, Pnnt.) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAN AYALA CERROS/MOTHER 4714 MEDORA DRIVE, SUITLAND, MD 20746 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State HERITAGE MEMORIAL 7-7-2012 WALDORF, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service 22. Name and Address of Facility POPE FUNERAL HOMES. P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 701055 Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interva Between Onset and /Medical a Drowning Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last the attending physician and led for use as the bunal - transi Physician/Medical \blacksquare AMENDED #1 as noted, per me, g929 7-17-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Dev Year Pregnant at time of death 5 [Other (Specify) 1 Yes 2 No 9 Unknown Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?

Yes 2 No 25. Wes case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Hospital. 1 Inpatient Other Nursing Home 5 Residence 6 X Other: 2 ER/Outpatient 3 DOA 1 X Yes 2 No 28a. Date of Injury FOUND: Manner of Death 28h Time of Injury 8c. Injury at Work 28d. Describe how injury occurred 1 Natural FOUND: Subject drowned in Chesapeake Bay after Pending 1 Yes 2 X No 24 hours after death. To the Funeral Director: completely filled in by the ificati 1905 hrs boat capsized Jul 1 2012 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Locetion (Street and Number or Rurel Route Number, City 3 Suicide Could not be or Town, State) 4 Homicide determined (Specify) Bay <u>Chesapeake Bay</u> 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 2, 2012 10 30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31 Date filed (Month, Day, Year) 32 Registrer's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ronald Melvin Cox

OCME

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| | | 1- For State Registrar | | | Certific | cate of | Death | | | | | Reg. N | | U | form. | Ca Sa "8" |
|---|--|---|-------------------------|-----------------------|-------------------|--------------|--|----------|------------------|------------|-------------------|--------------------------------------|----------------|-----------------------|-------------|---------------------|
| Physic | | 1. Decedent's Name (First, N | Middle,Last) | | | | | | | 2 | . Date of De | ath | | | 3. Time o | of Death |
| Medical Exam | ine | Kollatu | Melvin Co | | | | | | | | Month July 12, | | | | | 6 hrs |
| 3 | | 4a. Facility Name (if not inst. 421 Highmeadow | | number) | | 4 | 4b. City, Town, or Location of Death Baltimore County | | | | | 4c. County of Death Baltimore Cou | | | | |
| Funeral | | Social Security Number | 6. Sex | 7 Age (| In yrs. last bi | irthday\ | If Under 1 | | If Under: | 24Ure | 9 Data of F | lirth / 3 49 | M/DD/YYYY) | | . * | tata or |
| Director | | | | | | • • | Months | Hours | Min. | | | | Foreig | n | | |
| | | 263-69-2006 1 X M 2 F 48 Yrs. Aug 2 Usual Residence of Decedent | | | | | | | 5, 1963 C | | | untry) | MD | | | |
| any | | 10a. State 10b. Cou | n | | | | | | | | 10d. Insi | de City Limits | | | | |
| | L | MD Baltimore Reisterstown | | | | | | | | | es 2 X No | | | | | |
| Maryland 28a-f show 1 at once. | 용 | 10e. Street and Number | <u> </u> | | | Kers | 10f. Zip Co | | | | - 1 | 10a C | itizen of Wh | izen of What Country? | | |
| he Ma or 2 | Director | 421 Highme | adow Road | | | | | 113 | 6 | | | | | | | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. | Ē | 11. Marital Status | | ecedent Ev | er in U.S. | 13. Was | | | | 2 (Snec | ify Yes or N | U.S.A. | | | | Black |
| leath r item | Funeral | 1 X Never Married 2 | Married Armed | Forces? | l No | | s, specify C | | | | | | White, | | ,, | |
| ufter o | by F. | 3 Widowed 4 | Divorced If Yes, Give Y | | NO | 1 . | res 2 X | No s | specify: | | | | Specify: | WH | ite | |
| ours a | 8 | 15. Decedent's Education (| Specify only highest gr | ade comple | eted) 16a. | . Decedent's | | | | | | 16b. | Kind of Bus | | | |
| 6 172 h | Completed | Elementary/Secondary (0- | 12) College | (1-4 or 5+) | | auring mos | st of working | | | se retired | 1) | | | | | |
| 903 withir iene. | Ĕ | 12 | | | | | Lock | smi | th | | | Lo | cksmi | th (| Compa | any |
| Hyg doth | | 17. Father's Name (First, Mic | • | | | | | 18. | | | | | n Surname) | | | |
| 21215-0036 wild be filed within 7 Mental Hygiene. marked other than | Be | Ronald 19a. Informant's Name/Relat | Melvin Cox | , Sr. | | N | | | | | dred I | | | | | |
| MD 2 rd 2 shou dth and h m 27 is n | ဥ | | , | a | | | | | | | | | City or Town | | | |
| and 2 sealth tem 2 traum | | Diane Karr 20a. Method of Disposition | | Siste | r 4 20b. Place | | | | | | eistei Date | | Location - 0 | | | 21136 |
| Ore ges 1 t of H t tf H | | 1 Burial 2 X Crema | ation 3 Removal | from State | | tory or othe | | | ,, | | | | . Education | Jity Of 1 | | |
| Baltimore, Permit. Pages I as Department of Hee Important: If ite | | 4 Donation 5 Othe 21. Signature of Funeral Sen | | | Carro | 11 Cr | | | | | 3/12 | | mpste. | | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. | | 21. Signature of Funeral Sen | vice Licensee | _ 1 - | _ | ı | me and Add | | | | | | terst | | | |
| Physician | | 23a. Part I. Enter the disease | or emplications that | caused the | death. Do n | ELI | NE FU. | NERA | AL HO |)ME] | Reiste | erst | OWn, | MD | 2113 | 36 mate Interval |
| /Medical | | failure. List only one ca | use on each line. | | | | mous or ay | ing, ou | G 7 G 0 0 0 1 C | 1000110 | opiratory ar | 1031, 31 | lock, of field | ` | Betwee | en Onset and |
| Examiner | | Immediate Cause (Final dise or condition resulting in deat | | | | | | | | | | | | | | Death |
| | | Sequentially list conditions, | b | | | | | | | | | | | - 4 | | |
| | ner | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | | | | | | | | | | | | | |
| | ami | (Disease or injury that initiate | | | | | | | | | | | | | | |
| xecuted n and - transit | Exa | evolus researing in dealing La | d. | | | | | | | | | | | ı | | |
| ਾ ਕੋਵ | n/Medical | UNPENDED | AMENDED | | | | | | | | | | | | | |
| 8760, tificate be ex ng physician ts the burial | ¥ | IF FEMALE: | | | of pregnancy | | | | | | | 23 | 3d. Date of d | elivery | | |
| x 68 h certifi tending use as t | ä | 23b. Was decedent pregnant i past 12 months? | Live | birth nant at time | | 2 Fetal | | 3 | Ectopic pr | regnancy | | | Month | Da | ay | Year |
| Box 68 e death certi the attending ed for use as | Physicia | 1 Yes 2 No 9 | Unknown 9 Unkr | | s or death | 5 Othe | r (Specify) | | | | | 1 | | | | |
| D. B. tr the de by the ached f | | Part II. Other significant cor | | | t not resultin | g in the und | lerlying cau | se give | n in Part I | | 23e. Did t | obacco | use contrib | ute to th | ne cause | of death? |
| ires that the signed by I be detach | <u>a</u> | | | | | - | | | | | 1 Ye | s 2 | / No 3 | Proba | ably 4 | Unknown |
| ds, requir | Completed | | | | | | | | | _ | 24a. Was | an | 24b. We | ere auto | opsy findir | ngs available |
| CO law law e has t | 립 | | | - | | | | | | _ | auto | rmed? | pride | | | of cause of |
| tal Rec tian: The l certificate l ector, page | | 05.14 | | | | | | | | | 1 ✓ Yes | 2 🗌 N | | ✓ Yes | . 2 | P No |
| Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be | å | 25. Was case referred to med examiner? | Hospital: | Inpatient | <u> </u> | | _ | | Death (Ch | | | | | | | - |
| Of V ing Phy After thi uneral d | P | 1 ✓ Yes 2 No 27. Manner of Death | 28a Date | of Injury | | utpatient : | | | 4 ∐ N t Work? | | | _ | ury occurred | | Scene | - |
| nding th. | <u>ē</u> | 1 Netural | ending FOUNT | h, Day,Year) D: | | JND: | · _ | | 2 ✓ No | le. | bject sho | | dry occurred | 1 | | |
| isic Atte er dea recto | <u> </u> | 2 Accident In | vestigation Jul 12, | | - At home, fa | 5 hrs | | | | | Location (| Stroot | and Number | or Dur | al Dougla A | Number, City |
| Div pital or cours after | Certification: | | odid flot be | | Family H | | idotory, onto | Je bullo | iiig, etc. | | or Town, S | State) | d, Reisters | | | Jumber, City |
| Hospi 24 hou Funct | | 20a Cartifica | Physician: To the be | | | | at the time | date | and place | | | | | | | |
| | Medical | one) 2 Medical E | xaminer: On the basis | of examina | ition and/or i | nvestigation | n, in my opin | ion, de | ath occur | red at the | e time, date | and pla | ace, and due | to the | cause(s) | |
| To wit | ₹ | 29b. Signature and title of cer | and manner : tifier | stateu. | | | 29c. Lice | ense nu | ımber | | | 29d. | Date signed | (Mont | h, Day, Ye | ear) |
| | | D 7 1 | 1 | | | | 0. | C.M.E | ≣. | | | July | / 13, 2012 | 2 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) | | | | | | | | | | | | | | | |
| | | Donna M. Vincenti, | MD Assistant I | Medical B | Examiner | 900 W | . Baltimo | re St | reet, Ba | altimor | e, MD 21 | 223 | | | | |
| St Regist | | 31. Date filed (Month, Day, Yea | | egistrar's S | ignature | , | | | | | | | | | | |
| | _ | JUL 1 7 | 2012 | dendo | 1. 1 | park | / | - | | - | | | | | | |
| DHMH 17 Rev 1/20 | 100 | | OCME | | O'R | IGINAL | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2012 Michael Charles Cummiskey, III JMTV 14. 12:00 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)
April 30,1938 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 222-22-2330 Pennsylvania Director 1 ₹ M 2 □ F 74 Yrs Usual Residence of Decedent r then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖔 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 6310 Chesworth Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was becedent even in 0.5.

Armed Forces?

1 ☑ Yes 2 □ No
If Yes, Give
Year or Dates. Air Force à 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Systems Analyst Social Security and 2 should be filed witi Health end Mental Hygier tem 27 Is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael C. Cummiskey, Jr. Pauline Jellison Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 6310 Chesworth Rd. Baltimore, Maryland 21228 Mrs. Jacqueline C. Cummiskey or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Pege 1 a
Depertment of H
Importent: If ite
eny Injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 7/17/2012 Towson, Maryland 21. Signature of Fune al Service License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYELODYSPLASTIC SYNDROME disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury) Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physicien: The law requires that the death certificete be ex 24 hours after death.

24 hours after death.

5 Funerel Director: After this certificate has been signed by the ettending physicien etely filled in by the funeral director, page 2 should be detached for use es the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical examiner?

1 Yes 2 X No 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 5 Pending 1 Yes Investigation М 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the only one 29b. Signature and 29d. Date signed (Month, Day, Year) 10x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Sign **State** JUL 1 7 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RITES Month 2012 July Medical 4a. Facility Name (if not stitution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3 Aberdeen Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months (Month, Day, 220-07-6362 Hours Min 3 **Director** Usual Residence of Decedent 28a-f show oncome and Medial Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen D 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? Funeral 21001 US. be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER Z injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ ober RIENd permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic: once. 19a. Informant's Name/Relationship (Type, Print) drughten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 7-19-2012 HAUTE DEGRACE, MD 4 Donation 5 Other (Specify) Fuveral Service Licensee TARRING-CARGO F.H. P.A. 22. Name and Address of Facility Aberdeen MD 2100, PARKE S+ 23a. Part 1 Priter the disc ase shock, or heart fail' re. Is Immediate Cause (Fin 1 disease or condition southing in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between chy dralus Onset and Death Physician. Medical resulting in death) Due to (or as a consequence of): Streture Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant
Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No Yes 1 Yes Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury 1 Natural Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year, Whans 7116112 032609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allization

\\ DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUL 1 7 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shaquan Jamal Curtis State of Maryland / Department of Health and Mental Hygiene 2012 22467 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 12, 2012 Shaquan Jamal Curtis 0305 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Columbia 5337 Coulumbia Road Howard 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Country) MD Director Sept. 25,199 213-43-5755 17 1K M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits in. 10c. City. Town or Location 10a. State 10b. County 1X Yes 2 No Baltimore 28a-f shov MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygien. Department of Health and Montal Hygien is full matural?, ar items 23a nr 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2232 Penrose Ave. 14. Race - American Indian, Black, Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Gas Station Laborer 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Taylor Kendrick A. Martin Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendrick A. Martin 4234 Nadine Dr. Balto,Md. 21215 (father) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 🦳 Removal from State crematory or other place) July 21,2012 Mt. Zion Cem. Balto, Md. 4 Donation 5 Other Specify: ²² Name and Address of Facility
Calvin B. Scruggs Funeral Hon
1412 E. Preston St. Balto, Md. 21. Signature of Funeral Service License 21213 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of); Examine cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Sa UNPENDED AMENDED attending physician for use as the burial -Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown icate has been signed by the page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No certificate 1 🗸 Yes After this certific 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA 1 Yes 28a. Date of Injury (Month, Day Year) Jul 12, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto fixed object collision 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the ful 0300 hrs 1 Yes 2 V No 5 Pendina 2 Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 5337 Columbia Road, Columbia, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number July 12, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)-32. Repistrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :20A M COHEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical saltimore 10WSOY If Under 24 Hrs. 6. Sex If Under 1 Year **Funeral** . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. (Month, Day, Year) Director 212-32-5307 1 🖾 M 2 🗆 F 77 08/15/1934 MD Usual Residence of Decedent show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be by Funeral 6317 LA GRANGE LANE 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **PSYCHIATRIC** Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WORKER COUNSELING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 COHEN HENRY DOROTHY STELMACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 APRIL COHEN/WIFE 6317 LA GRANGE LANE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM | 07/13/2012 REISTERSTOWN, MD 21. Signature of Funoral Service Line 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Betwee Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) SDIRATORI days Medical Due to (or as a consequence of) Examiner reumonic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Kesponse and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Hulmonary 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed oronaru Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital: After this funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? Accident Suicide 2 No Director A Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours at er c

To the Funeral Direct

completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on 29b. Sig 29c. License number ed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Drive Suite 409 Towson M.D State Registrar

DHMH 17 Rev 06-2011

| | | State Registrar | | | Cen | tificate of | Death | | Reg. No | 0. | | |
|---|--------------|--|--|----------------|---------------------------------------|---|-----------------------------|---|--|--|--|--|
| Physici Medi | | 1. Decedent's Name (First, Middle, Last) Betty Whe | eler | Dick | inson | | | 2. Date of D | | 2012 Year | 3. Time of Death 12:10 p м | |
| Exami | ner | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charlestown Care Center 4b. City, Town, or Location of Death Catonsville | | | | | | | | c. County of Death | | |
| Funeral Director | | 216 22 7017 | $9-32-7917$ 1 \square M 2 \square F 98 Yrs. Months Days Hours Min. (Month, Day Feb. 8 | | | | | | | | lace (State or Foreign ry) h Carolina | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Director | 10a. State 10b. County MD Carroll | | 10c. City, To | own or Loc | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No | | |
| a or 2 be no | | 10e. Street and Number | | | | 10f. Zip Code | | | | itizen of What Coun | | |
| ith with ms 23 must | Funeral | 5579 Linton Rd. | 0.14 0.11 | | Lie | 21284 | | | USA | | | |
| 036 s after dea ral", or ite | þ | 11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced | 2. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates. | | lf lf | /as Decedent of F Yes, specify Cub ☐ Yes 2 ★ No | an, Mexican, Pue | (Specify Yes or No erto Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15-0 72 hour n "natu fedical | Completed | 15. Decedent's Edu (Specify only highest grad | 1 | (Give ki | ent's Usual Occup ind of work done | during most of w | vorking | 16b. k | Kind of Business/Ind | lustry | | |
| 212 within giene. | e Con | Elementary/Secondary (0-12) 2 | College (1-4 or 8 | 5+) | Teac | NOT use retired, her | | | Balı | timore Co | unty | |
| Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o rtraumatic event, the Medical Exam | To Be | 17. Father's Name (First, Middle, Last) Wilson Moore | Whee | | | | lame (First, Middle Hugh | e, Maiden | Surname) Inge | | | |
| Mar and 2 shou lealth and im 27 is in her traum | 9 | 19a. Informant's Name/Relationship (Typ Richard N. Dickins | |)]. | 5579 | Linton R | | Rural Route Numb | | r Town, State, Zip C 21284 | ode) | |
| nore | | 20a. Method of Disposition 1X Burial 2 Cremation 3 F | lemoval from State | Dufa | ffev crev | ition (Name of at 1710 other pla | ce) 7/ | Date 18/12 | 1 | ocation - City or To | | |
| Baltimore, oermit. Page 1 and Department of Hea Important: If item any injury or other once. | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser | | Memo | orial 22. | Gardens Name and Addre | | | | laney Vali ineral Hor | | |
| a 59 a 8 | - 3 | | | | | | | | | re, MD 212 | 229 | |
| Physician/ Medical | | 23a PART. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) | cations that caused cause on each lin | the death. D | rai | tion | pru | ac or respiratory a | | 7 | Approximate Interval Between Onset and Death | |
| Examiner | | | Due to (or as | a con equen | ce of | from | Ha | | | | | |
| sit d | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as | a consequen | ce of): | tvor | lel | | | | | |
| execute an and nial-tran | | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequen | | | | | | | | |
| 68760 ertificate be ding physicik se as the bu | /Medical | | | | | | | | _ | | | |
| Box death or death or he attenned for u | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | Bc. If yes, outcome 1 Live Birth 4 Pregnant a | 2 L Fetal de | etal death 3 L Ectopic pregnancy | | | | | ry Day Year | | |
| IS, P.O. uires that the n signed by t | by | Part II. Other significant conditions con | conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 □ Yes 2 □ No 3 □ | | | | | | | | | |
| Vital Records, sician: The law requires rectificate has been signirector, page 2 should b | Completed | | | | | | | perf | opsy ormed? | prior to con death? | sy findings available apletion of cause of | |
| | Be C | 25. Was case referred to medical examiner? | agnital: | | | | lace of Death (Ch | | 2+1N | 0 1 □ Yes | 2 LI NO | |
| Physi Physi rthis c eral din | 9: To | 1 Yes 2 No | ospital: 1 ☐ Inpati 28a. Date of inju | ent 2 ER | /Outpatient b. Time of | 3 DOA Oth | 4 LTNursing | Home 5 Res | | 6 Other (Specify) | | |
| ISION Of VItal Attending Physician: or death. ector: After this certific by the funeral director, | Certificate: | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day | y, Year) | injury | work | Yes 2 No | 28d. Describe | now injur | y occurred | | |
| ≥ કેલ્લેક્ટ | P 1 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubulding, etc | c. (Specify) | | | | City or To | wn, State | | | |
| Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in | Medica | 29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse | r: On the basis of e | xamination an | nd/or investig | ration, in my opini | on, death occurre | dat the time date | and place | and due to the caus | se/s) and manner stated | |
| To To t | | 29b. Signature and title of certifier | Jan | | NIS | 29c. Licens | e number | 240 | 29d. Da | tte signed (Month, D | ay, Year) | |
| 2 | | 30. Name and address of person who co | mpleted cause of d | eath (Item 23 | a) (Type, Pr | int) | Tho: | i Can | e, (| Colon | male | |
| Sta Registr | | 31. Date filed (Month, Day, Year) | 32 Registra | ar's Signature | 1. | | | | | | 2/228 | |
| DHMH 17 Rev 06- | | JUL 1 7 2012 | Letens | p. | Mar | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Warda Duvall 6:06PM 07 2012 10 Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death Baltimore Memorial yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 3010 (Month, Day, Director 1 🗆 M 2 💆 Mar. 15 Mar land 28a-f show 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral Kever and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ð 1 Never Married 2 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give ack 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify only highest grade completed) Il Hygiene. College (1-4 or 5+) Be 17. Father's Name (First, Middle, La other's Name (First, Middle, Maiden Surname and Mental I ပ္ Paula Oveen other traumatic Department of Health ar Important: If item 27 is any injury or other trau SISTE lamiotsville Rd. 20b. Place of Disposition (Name of Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Interval Between 2 NEEKS Immediate Cause (Final Physician. depsis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

9

Registrar

31. Date filed (Month, Day, Year)

Year) 32. Fegistrar's Signature

201 E UNIV

PARK WAY

MD

21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11^{Day} 2012^{eai} $\mathbf{J}\mathbf{u}\mathbf{l}\mathbf{v}^{ ext{nth}}$ Betty R. Davis 12:25 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Aug. 29 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 F Min 1916 Yrs Director 577-24-5992 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director Gaithersburg Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 20877 United States 301 Russell Avenue, #438 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ö þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the School System 5+ Teacher of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mabelle Milligan William Runner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28146 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 i or other tra 785 Cantiberry Drive, Salisbury, North Carolina William Davis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Metro Crematory Inc. 07/12/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alvson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oneet and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events the Hospital or Attending Physician: The law requires that the death certificate be exect thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician an Due to (or as a consequence resulting in death) Last Division of Vital Records, P.O. Box 687606 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rgestino 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 29d. Date signed (Month. Day, Year) Makert Be 04115 uly 11,2012 θ_{\prime} RUSSELL THEISBUR 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Monthy Physician/ MOBERLY -ZABETH Medical 4c. County of Death Facility Name (if not institution, give street and number, 4b. City, Town, or L **Examiner** MARYLAND HEALTH CARE If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 10/8/1918 1 □ M 2 🔀 F Virgi<u>nia</u> Director 93 220-10-5812 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Bel Air Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral or items 23a S. 21014 Α. 713 Deep Ridge Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 194
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. ^{2 No} 1943 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", i any injury or other traumatic event, the Medical Exan White 3 X Widowed 4 Divorced Completed 1953 Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Archdioces of Baltimore Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Fudora Mactier Harold K. Moberly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 713 Deep Ridge Road Bel Air, Maryland 21014 Frederick Michael Dierken (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 7/17/2012 1 Marial 2 ☐ Cremation 3 ☐ Removal from State Overlea, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gard. Gardens of Faith Mem. 22. Name and Address of Facility
Bruzdzinski Funeral Home
1407 Old Eastern Avenue Signature of Funeral Service Licenses Home PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final 515 ₽nysician/ disease or condition resulting in death) Medical Examiner EMENTIA Sequentially list conditions, if any leading to minedich cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of use as the burial-transit within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopu performed: 2 X No death? 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner?
1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 2 Accider 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

SHANDELYA

DHMH 17 Rev 7/2009

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

7239

29d. Date signed (Month, Day, Year)

MD 21902

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15^{Day} Physician/ y**r**mu 20**12** 2:31 A M Derr Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year, 228-32-5848 Director 1 □ M 2 🗓 F 83 July 2, 1929 Washington, DC Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show amy injury or other traumatic event, the Medical Evan that must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21228 331 Greenlow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. چ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen G. Greer Leonard H. Brown, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 331 Greenlow Road Baltimore, Maryland Mark Derr Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/16/2012 Towson, Maryland 4 Donation 5 Other (Specify) HilltopServiceCorp 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral 8- vice Licens 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ÛNo
9 ☐ Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defining hysical in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 15,2012

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHANLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ July 13 11:30 A M Dickens - Nichols Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🂢 F Director Maryland 236-98-6447 September 2,1958 Yrs 53 10d. Inside City Limits 10b. County 10c. City, Town or Location Paga 1 end 2 should ba filiad within 72 hours efter deeth with tha Merylend ment of Heelth and Mental Hyglane. ent: If Item 27 is marked other than "neturel", or Items 23e or 28e-f shoury or other traumatic avant, the Medical Examiner must be notified at 10a, State Directo Baltimore 1

Yes 2 □ No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 1629 Malvern Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married <u>۾</u> altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Machinist 9 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joyce Little William Dickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) sister 7054 Belclare Road, Dundalk, Maryland Diana Ayers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State July 18, 1 X Burial 2 Cremation 3 Removal from State parmit. Paga Department of Importent: If eny Injury or Holly Hill Memorial Grons Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Sonature Funcial Service License 22 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, Md. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Physician/ all yens disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The lew requires that the death certificate be executed attending physicien and I for usa es tha buriai-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death bean signed by tha a should be dateched t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificata hes bean si funarei director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 6 Other (Specify) WOSPICE 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending death. Director: A bid in by the f Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter of To the Funerel Direct completaly filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

201

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 20 M 70 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Himor 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🕟 Months Days Hours Min Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have matter and 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2120 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) VOV Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ dom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 prother Kd Hill o ltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place) 1 Surial 2 Cremation 3 Removal from State 3attimore 4 ☐ Donation 5 ☐ Other (Specify) 5 21. Signatur, of Funeral Service Liv 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Lindarying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death
Unknown Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 XNO Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature State 1 7 Registrar

| | | | | Pleas | e Type or | | | | | | | | - | | _ | ble. | • | | |
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| | | | For State | | State | of Ma | aryland | | | | | and M | lental Hy | /gien | e | 2 1 | 0 | 001 | 7/ |
| 1 | _ | Registrar 1. Decedent's Name (First, Middle, Last) 2. Dat | | | | | | | | | | 2. Date of De | Reg. N | 0. | | 137 | ime of Dec | ath. | |
| Evans | Physicia Medi | | Donnie M. | Evans | | | | | | | 2. Date of Death South 15 Day 120 12ear 41021 M | | | | | М | | | |
| , | Examir | ier | Sinai Hospital of Baltimore Baltimore City | | | | | | | | | | h | | | | | | |
| DOMNIE | Funeral Director | | 5. Social Security No. 248-32-6079 | 9 | Sex 1X M 2 □ F | 7. Age | (In yrs. Ia 86 | st birthday) Yrs. | If Under Months | 1 Year Days | If Unde Hours | r 24 Hrs. Min. | 8. Date of Bi (Month, D. 0-2-1 | rth av Vear) 926 | | | untry) | State or Fo | reign |
| 0 | land show det | tor | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | | | | | | | | | | | side City Li | | |
| A | Baltimore Randallstown | | | | | | | | | | Yes 2 | ∃No | | | | | | | |
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| 3 | leath items | Fun | 11. Marital Status | alula No | 12. Was Dec | edent E | ver in U.S | . 13. | Vas Deced | | | rigin? (Spe | cify Yes or No | - | 14. Race | - Amei | ncan Indi | ian, | |
| 2500 | permit. Page 1 and 2 should be filer within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f shown injury or other traumatic even, the Medical Examiner must be notified et once. | ted by | 1 Never Marri 3 🕅 Widowed | 4 Divorced | If Yes, Give Year or Dates. | | | . 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☐ No Specify: | | | | | nicari, etc.) | | i i | k, White | | merica | n |
| Pater know Baltimore, Maryland 21215-0036 | thin 72 ho ene. than "na | Completed | (Spe | | s Education grade completed College (1 | | +) | life. D | kind of woi O NOT use | rk done d | | st of worki | ng | | Kind of Bu | | | | |
| ₹ P | ilec wi | Be | 17. Father's Name (| | t) | | | Ba | rber | | 18. Mot | her's Name | e (First, Middle | | f-Emp. Surname) | | 1 | | |
| Pater e, Maryland | uid be t Menta narked | 욘 | Willis Eva | | | | | | | | Ha | ttie L | ane | | | | | | |
| ₹ Bar | 2 shouth and the and t | | 19a. Informant's Na Josephine I | | | | | 1 | - | | | | l Route Numb 1 stown, 1 | | | |) Code) | | |
| G o | 1 and of Hea litem | | 20a. Method of Disp | osition | | | | ace of Dispo | sition (Nan | ne of | | | Date | | Location - | | Town, St | ate | |
| ij | . Page iment tant: It | | | ☐ Cremation 3 5 ☐ Other (Spe | Removal from | n State | Cœd | emetery, crer ar Hill | | - | | 7 | /20/2012 | Bal | Ltimore | e, Ma | arylar | nd | |
| Balt | permit Depart Impor any in | | 21. Signature of Fu | eral rvice Lice | ensee | | | | | | | | Funeral Listown, | | | | | w. | |
| | | | 23a. Part 1. Enter t | he disease, or co | omplications that | caused | the death | | | | | | | | /ICIN 2 | | Appro | oximate | |
| | Physician/ Medical Examiner | | Immediate Cause (disease or condition resulting in death) | Final | a. Due to | CV | conseque | ence of): | 9 Q C | vel | | | | | | _ | | al Betweer t and Deat COU | |
| | LXAIIIIIei | ner | Sequentially list co if any, leading to in | mediate | b. Due to | (or as a | consequ | ence of): | | | | | | | | - | | | |
| 10 | executed ian and urial-transit | xami | cause. Enter Under Cause (Disease of that initiated events | injury s | c. — | , | | | | | | | | | | | | | - 1 |
| <i>P</i> 09 | ate be execut ohysician and the burial-tra | Completed by Physician/Medical Examiner | resulting in death) I | ast | d. | (or as a | consequ | ence ot): | | | | | | | | | | | |
| 687 | certifica nding p | n/Me | IF FEMALE: 23b. Was decedent | pregnant | 23c. If yes, ou | | | | - | | | | | | 23d. Date | of del | livor. | | |
|). Box 68760 | he death y the atte | hysicia | in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown | months?] No | | gnant at | 2 ∐ Fetal time of d | death 3 Death 5 D | Dectopic Other (sp | | y | | | | Mor | | Day | Year | |
| , P.O. | s that t gned b be deta | by P | Part II. Other signif | icant conditions | s contributing to | death be | ut not resu | ılting in the ι | nderlying | cause giv | ren in Par | t I. | | | use contri | | | | |
| rds | require been si should | eted | | | | | | | | | | | - | | / | | | 4 Unkr | |
| Division of Vital Records, | : The law icate has I | | | | | | | | | | | | 24a. Was auto perf 1 Yes | opsy formed? | , p | nor to o | topsy find completio | dings availa on of cause | able e of |
| /ital | s certifi | o Be | 25. Was case referred examiner? | ed to medical | Hospital: | V | | | | Othe | er | ath (Check | | 933 | | | | | |
| The spinal of th | | | | | | | | | | | | ity) | | | | | | | |
| sion | ttendi death, stor: A y the fu | Certificate: | 2 ☐ Accident 3 ☐ Suicide | Investigat | t be | a of Iniu | n/ - At box | ne, farm, str | M not factor | 1 🗆 | Yes 2[| - | 205 1 1' | (0) | | | 15. | • • | |
| Divi | pital or A ours after eral Direc | | 4 ☐ Homicide 29a. Certifier 1 | determine | build | ling, etc | . (Specify) | | | | -data as | ļ | 28f. Location City or To | wn, Stat | e) | | | Number, | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b. | 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 3 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 29b. Signature and title of certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | stated. | | | | | | |
| | F 3 F 8 | |) | | | _ | | M | 3 | DO | | 511 | 7 | J1 | 1LY | 13 | , Day, Yes | 2017 | 2_ |
| | 0 | | 30. Name and addre | ess of person wh 人みら (| o completed cau | se of de | | 23a) (Type, F | | A () | Hes | PITT | tc 09 | F J. | NT. | 111 | ORE | 5 | |
| | Sta | | 31. Date filed (Mont | h, Day, Year) | 7 2019 32.1 | Registra | r's Signati | ure A. A | parks | | | | | | | | | | |

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amend #5, per fh, g929 7-18-12 sm

State of Maryland / Department of Health and Mental Hygiene

| | | 1 | For State Registrar | State of Mar | | rtificate of l | | | Reg. No. 2 | 112 | 22477 | | |
|-------------------|---|---------------|--|---|--|--|--|---|-------------------------------------|------------------------------|--|--|--|
| i | Physicia | | 1. Decedent's Name (First, Middle, L | _ | | | | 2. Date of Dea | | Year 012 | 3. Time of Death 4:30 PM | | |
| Jan Jan | Medic | al | Mary 4a. Facility Name (if not institution, gi | Leoi | na | Engleman | or Location of Death | July | | | 1 2 2 2 L M | | |
| | Examin | er | Keswick Care Ce | | | Baltime | | | 4c. County of Death | | | | |
| | Funeral | | 5. Social Security Number 6. | | n yrs. last birthday) | If Under 1 Year Months Days | | 8. Date of Birtl (Month, Day | h | 9. Birthp Count | olace (State or Foreign trv) | | |
| | Director | | 217-14-0114 217-14-2220 Usual Residence of Decedent | 1 □ M 2 X F | 92 Yrs. | , | | 03/09/ | | | | | |
| | and show | ō | 10a. State 10b. County | 1 | 0c. City, Town or Lo | cation | | | | 1 | 0d. Inside City Limits | | |
| | Maryla 28a-f | Director | MD Baltin | nore | Parkvill | e | | | | | 1 🗌 Yes 2 🔀 No | | |
| | h the | | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | | try? | | |
| | ith wit | Funeral | 2816 Inglewood | venue 12. Was Decedent Eve | orin IIS 13 | 21234 | Hispanic Origin? (Spe | ecify Yes or No- | U.S.A. | ce - America | an Indian | | |
| ယ္ | er dea or ite miner | | 11. Marital Status1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 Yes 2 X No | | | Hispanic Origin? (Spe an, Mexican, Puerto | Rican, etc.) | | ick, White, e | etc. | | |
| 93 | ırs aft ural", I Exal | Completed by | 3 Widowed 4 X Divorced | If Yes, Give Year or Dates. | | 1 🗌 Yes 2 🔀 No | Specify: | | Specify | <i>i</i> : | White | | |
| 15-(| 72 hou "nati ledica | ple | 15. Decedent's (Specify only highest | | (Give | dent's Usual Occup kind of work done OO NOT use retired, | during most of work | ing | 16b. Kind of E | Business/Inc | dustry | | |
| 21215-0036 | within 72 hours after death with the Maryland giglene. her than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at | | Elementary/Secondary (0-12) | College (1-4 or 5+) | Oper | · · · · · · · · · · · · · · · · · · · |) | | C & P | Teler | phone | | |
| | filed v al Hyg d othe | | 17. Father's Name (First, Middle, Las | t) | | | 18. Mother's Nam | e (First, Middle, | | - | | | |
| ylaı | ald be fill Mental narked o | 욘 | Joseph | | | Wess | Nellie | | - | | norn | | |
| Maryland | 1 and 2 should be filed wit of Health and Mental Hygie item 27 is marked other other traumatic event, the | | 19a. Informant's Name/Relationship Donald Engleman | | 1.0 | | and Number or Rura Avenue, Ba | | | | (ode) | | |
| a) | Health tree tra | | 20a, Method of Disposition | | 20b. Place of Dispo | osition (Name of | | Date | 20c. Location | | wn, State | | |
| mo | Page 1 nent of int: If it | | 1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe | ☐ Removal from State cify) | cemetery, cre Moreland | matory or other pla Memorial | | 16/2012 | Baltin | nore. | MD | | |
| Baltimore, | permit. Page 1. Department of Important: If it any injury or o | | 21. Signature of Funeral Service Lice | | 2 | 2. Name and Addre | ess of Facility Led | onard J. | Ruck, | Inc. | | | |
| | 9 Q E # 9 | Ц | 23a. Part 1. Enter the disease, or co | | | | ord Road, | | | 21214 | | | |
| | er er er er er er er er er er er er er e | | 23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final | one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | | |
| | Medical | | disease or condition resulting in death) | | consequence of): | cure p | relimina | y aire | ase | | unteroco | | |
| 1 | Examiner | | | Preum | | | | | | | 10 days | | |
| | _ = | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a c | ionsequence of). | | | | | | | | |
| 36 | ecutec and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a c | consequence of): | | | | | - | | | |
| 7 | sate be executed physician and s the burial-transit | edical | | d | , , | | | | | | | | |
| 3760 | ficate g phy: as the | | | u | | | | | | | | | |
| × 68 | ath certific attending I for use as | an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | Fetal death 3 | | псу | | | ate of delive | ery Day Year | | |
| Box | e deat the at hed fo | Physician/N | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4 ☐ Pregnant at ti 9 ☐ Unknown | ime of death 5 l | Other (specify) | | | l lvi | Ontil | Day Teal | | |
| P.O. | es that the dea signed by the a I be detached I | | Part II. Other significant condition | contributing to death but | not resulting in the | underlying cause g | iven in Part I. | 23e. Did to | obacco use con | tribute to th | ne cause of death? | | |
| JS, I | requires t been sign should be | ed by | , | | | | | 1 🗆 ' | Yes 2 ☐ No | 3 🗌 Prof | babiy 4 Unknown | | |
| Sor | has bee | Completed | | | | | | 24a. Was autop | osy | prior to coi | psy findings available mpletion of cause of | | |
| Re | The la | Con | | | | | | 1 Ves | rmed? 2 No | death? | 2 🗆 No | | |
| ital | ysician: is certific director, | Be | 25. Was case referred to predical examiner? 1 Yes 2 M No | Hospital: | | - Int | Place of Death (Chec | | | (0) | | | |
| of Vital Records, | g Physer this leral d | e: <u>T</u> o | 27. Man or of Death | 28a. Date of injury | | of 28c. Inju | iry at | ome 5 \square Residence 28d. Describe h | | | 2 | | |
| on | ending Paath. | ficat | 1 Natural 5 Pending 2 Accident Investiga | | Year) injury | M 1 | Yes 2 No | | | | | | |
| Division | pital or Attene ours after deat eral Director: filled in by the | Certificate: | 3 Suicide 6 Could no 4 Homicide determin | | r - At home, farm, st (Specify) | reet, factory, office | | 28f. Location (S City or Tow | Street and Numl vn, State) | oer or Rural | Route Number, | | |
| Ö | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic. | | | hysician: To the best of m | | | | | | | | | |
| | To the Hos within 24 h To the Fun completely | Medical | (Check 2 Medical Ex- only one) 3 Certifying N | miner: On the basis of exa urse Practitioner: To the b | mination and/or inve best of my knowledge | stigation, in my opin e, death occurred at | nion, death occurred a t the time, date and p | at the time, date a lace, and due to t | and place, and d he cause(s) and | ue to the cal manner as s | use(s) and manner stated. stated. | | |
| _ | With To the | | 29b. Signature and title of certifier | 700 Anos | W. OID | 29c. Licens | 3 6 5 7 | | 29d. Date signe | | | | |
| | 11 | | 20 November V | a completed sauce of dea | | | | | Turky 1. | | . 00 | | |
| | 7 | | 30. Name and address of person when the state of the stat | | 700 W. | to the STA | CEET, BE | LLTID OR L | 5,000 3 | 21211 | | | |
| | Sta Registr | | 31. Date filed (Month, Day Year) 20 | 12 A32. Registrar's | s Signature | Ked | | - | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2:00 PM Emerson July 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Director 079-28-8695 1 □ M 2**X X** 87 June 11, 1925 United Kingdom ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Silver Spring 1 Yes 2 XNo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10214 Royal Rd. 20903 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1XXNever Married 2 Married ģ 2 X No should be filed within 72 hours after and Mental Hygiene. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) 12 Legal Secretary Legal / Law marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 01iver George Edward Lione1 Emerson Winifred Elizabeth other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,s nit. Page 1 and 2 shartment of Health a Julius Aruna / Friend 10214 Royal Rd., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State Chesapeake Crematory 07/17/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS WEEKS Medical resulting in death) Due to (or as a consequence of) **Examiner** WEEKS RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami the Hospital or Attending Physician: The law requires that the death certificate be executed PNEUMONIA WEEKS Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death the : 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ATRIAL FIBRILLATION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed?

1 Yes 2 No death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 X No မ XX Inpatient 2 - ER/Outpatient 3 - DOA After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XXNatural 5 Pending work? 1 ☐ Yes 2 ☐ No neral Director; A filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar M DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

SURESH K. GUPTA,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

D32332

9801 GEORGIA AVE. #220, SILVER SPRING,

29d. Date signed (Month, Day, Year)

JULY 14, 2012

20902

| | | | For State | State of M | arylan | | | | | and M | 1ental Hy | gien | e 20 | 12 | 22479 |
|----------------------------|---|--------------------------|--|---|--|-------------------------------|----------------------------|--------------------------|----------------------------|-----------------|-----------------------------------|--------------|----------------|-------------|--|
| | | aro | Registrar 1. Decedent's Name (First, Middle, Las | t) | | Cer | tificate | e of L | Death | | 0.0-4 | Reg. N | lo. | | T |
| | Physicia | | David Dickey Fas | , | | | | | | | 2. Date of De | | - | ear | 3. Time of Death |
| | Medic Examin | | 4a. Facility Name (if not institution, give | | | - | 4b. City, | Town, or | Location of | of Death | 1017 | | c. County of | Death | 16-1-1 |
| - | <i>)</i> | | Seasons Hospice | | 7. Age (In yrs. last birthday) If Under 1 Ye | | | | | | | Baltimore | | | re |
| | Funeral Director | | 5. Social Security Number 6. Sec. 212–42–8856 | ex 7. Aga K∆M 2 □ F | | | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da | | , | B. Birth | olace (State or Foreign try) |
| | | | Usual Residence of Decedent | ©M 2 □ F | 68 | Yrs. | | | | | April | 8 1 | 944 M | ary | land |
| | f sho | tor | 10a. State 10b. County | | | y, Town or Loc | | | | | | | | 1 | 0d. Inside City Limits |
| | e Mar | Direc | Maryland Baltimo | re | Bal | timore | | | | | | | | \perp | 1 🗌 Yes 2 🐔 No |
| | within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. | Funeral Director | 10e. Street and Number 1309 Glendale Re | oad | | | 10f. Zip | 212 | 739 | | | 10g. (| U.S.A | | ntry? |
| | eath v tems | Fune | 11. Marital Status | 12. Was Decedent E | ver in U.S | | Vas Deced | ent of Hi | spanic Ong | gin? (Spe | cify Yes or No- | | 14. Race - | | an Indian, |
| 36 | s after deat ral", or iter Examiner | þ | 1 Never Married 2 Married | Armed Forces? 1 12 Yes 2 1 If Yes, Give | No | | _ | - | n, Mexican Specify: | | Rican, etc.) | | Black, | White, | etc. |
| 8 | ours atural | Completed | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education | Year or Dates. | | 16a. Deced | | | | | | | Specify: | | |
| 215 | n 72 h an "n Medi | dm | (Specify only highest gra Elementary/Secondary (0-12) | | | (Give k | ind of wor NOT use | k done d retired) | luring most | t of worki | ng | | Kind of Busin | | |
| 2 | 1 withi ygiene her th | a) | | 4 | | Videog | graph | er | | | | Uni | versi | ty c | of Md. |
| Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours aft Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examone. | To B | 17. Father's Name (First, Middle, Last) | 200 | | | | | 18. Mothe | | e (First, Middle, Kathe) | | , | 20 | |
| ary | nd Me | ĺ | John Francis Fa | igan rpe. Print) | | 19h Mailin | a Address | (Street a | | | I Route Numbe | | | | Sadal . |
| Ž | id 2 st salth a n 27 is er tra | | Barbara Fagan / W | life | | 1309 | Glen | dale | Road | l, Ba | ltimore | =, N | larylar | nd | 21239 |
| Baltimore, | t of He If item or oth | | 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ | Removal from State | 20b. P | Place of Dispos | sition (Name | e of ther place | e) | | Date | 20c. | Location - Ci | ty or To | wn, State |
| tim | it. Pag rtmeni rtant: njury o | | 4 Donation 5 Other (Specification) |) | Hil: | ltopSer | | | | | 2012 | | son, l | _ | |
| Bal | Depar Depar Impo any ir | | 21. Signature of Funeral Sorris Licens | ee | | 10 10 | Name and | d Addres Ork | s of Facility Road | Ruck Tow | Towson, Ma | n Fu aryl | neral and 2 | Hon 2120 | ne, Inc.)4 |
| | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or | blications that caused ne cause on each line | the deat | h. Do not ente | r the mode | of dying | g, such as | cardiac o | r respi <i>ra</i> tory ar | rest, | | | Approximate Interval Between |
| | Physician/ Medical | | Immediate Cause (Final disease or condition resulting in death) | a | 17 | | 14 C | er | | | | | | \perp | Onset and Death |
| | Examiner | | | Due to (or as a | a co n≲ equ | uence of): | | | | | | | | | |
| | + | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a | consequ | uence of): | | | | | | | | \top | |
| | ate be executed bhysician and the burial-transit | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | | 10000 00: | | | | | | | | \perp | |
| 0 | be exi | calE | resulting in death) Last | . Due to to as a | consequ | derice oi). | | | | | | | | | |
| 3760 | | w L | | d | | | | | | | | | | 土 | |
| Box 687 | h certi tendin or use | an/ | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome | of pregna 2 Feta | ncy al death 3 🗆 | Ectopic p | regnancy | v | | | | 23d. Date of | of delive | ery |
| | e deat the at thed fo | ysic | 1 Yes 2 No | 4 ☐ Pregnant at 9 ☐ Unknown | time of d | death 5 | Other (spe | ecify) | | | | | Month | | Day Year |
| P.O. | that th | Completed by Physician/M | Part II. Other significant conditions co | ntributing to death be | ut not res | ulting in the ur | nderlying c | ause give | en in Part I | | 23e. Did to | obacco | use contribu | te to th | e cause of death? |
| | quires en sign | ed b | | | | | | | | | 1 🗆 | Yes 2 | 2 □ No 3 l | ☐ Prob | pably 4 Unknown |
| Sor | aw rec as be | ple | | | | | | | | | 24a. Was auto | | | | osy findings available mpletion of cause of |
| æ | : The cate h | ខ្ល | | | | | | | | | perfo | rmed? | dea | th? | 2 N o |
| /ital | sician certifi irecto | 00 | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | | | | Othe | ce of Deat | | | | | _ | 70.11.00 |
| ð. | g Phy er this neral d | te: To | 27. Manner of Death | 28a. Date of injur | у | ER/Outpatient 28b. Time of | | Bc. Injury | at Nu | | me 5 L Residence 128d. Describe h | | | Specify | InP+ Hospice |
| <u>o</u> | tendin leath. or: Aff the fu | ifica | 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be | | rear) | injury | М | work? | Yes 2 🗆 | No | | | | | |
| Division of Vital Records, | or Att after d Direct in by | Certificate: | 4 Homicide determined | 28e. Place of Inju building, etc | | | et, factory, | office | | 1 | 28f. Location (S City or Tow | | | r Rural | Route Number, |
| ۵ | spital hours neral y filled | Medical | 29a. Certifier Certifying Phys | ician: To the best of | ny knowl | edge, death o | ccurred at | the time, | , date and | place, an | d due to the ca | ause(s) | and manner a | as state | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | | (Check 2 Medical Examination only one) 3 Certifying Nurs | ner: On the basis of ex | amination | and/or investig | gation, in m death occu | ny opinion rred at th | n, death oc e time, dat | curred at | the time, date a | ind plac | e, and due to | the cau | ise(s) and manner stated. |
| | ្ត ។ Ki | - | 29b. Signature and title of certifier | 1 - | 13 | 20 | | License | | -7 | | | ate signed (M | | |
| | | ŀ | 30. Name and address of person who co | ampleted cause of de | ath (Item | 23a) (Type Pr | int) | /) | , 0) | - | | | 414 | | 16 2016 |
| 6 | | | | ebach | M | 0 | 69 | 74 | AU | plat | Den B | 7/4 | 1 2 | -10 | 06/ |
| | Stat Registra | - | JUL 1 7 2012 | 32. Registra | rs Signat | park | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ July 74. 2012 11:40 A M Norma Bertha Foster Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab & Nursing Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year, Director 217-12-9098 1 M 2 X F Maryland 1924 Sept 6, 87 10b. County 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Yes 2 X No Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 8300 Plum Creek Drive 20882 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married and 2 should be filed within 72 hours after. Health and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Buyer Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Brunner Margaret Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Foster / Daughter 8300 Plum Creek Dr. Gaithersburg, MD 20882 Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/17/12 Woodbine, Maryland Funeral Service Licensee Signaturi Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Parkinson's Disease, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy Yes 2 X N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural iniurv

Division of Vital Records, P.O. Box 68760 Benthi NORMA

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t filled in by

Medical

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date signed (Month, Day, Year)

July 16, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

Anuradha Arun 10301 Georgia Ave. Ste. 209 Silver Spring, MD 20902

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) State

2 Accident
3 Suicide

29a. Certifier

(Check only one

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Ju^{Month} 8:10 рΜ Lorraine G. 13 Franz Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Emeritus Senior Living <u>Pikesville</u> <u>Baltimore</u> Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) **Director** 475-18-6804 1 🗆 M 2 🗶 F 90 Yrs May 16, 1922 MN Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No MD Baltimore Towson 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? þe Funeral "natural", or items 23a 208 Linden 21286 Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Completed 3 X Widowed 4 ☐ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifford E. Davey Isabe1 Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry B. Franz, III 1305 Kingsbury Rd. Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date ō **≟ ₀** Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Ind 7-16-2012 Hampstead, Maryland Signature of Funeral Rervice Licensee 22. Name and Address of Facility ELINE FUNERAL HOME m ron 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or injur that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of Adrial 24a. Was an autops\ death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number D0041291 2012

DHMH 17 Rev 06-2011

State Registrar 200

nortra 31. Date filed (Month, Day, Year) 1838

Greene Tree Rd.

ress of person who completed cause of death (Item 23a) (Type, Print) MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 6:51 A M July $1^{2}4$ Frenkil Physician/ Nancy Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore **Examiner** Reisterstown 3850 Butler Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Year) **Funeral** 218-32-6853 76 1 M 2 X F Yrs. 1936 Maryland Director Dec 12. 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 Yes 2 X No Reisterstown Baltimore -28a-f MD. 10g. Citizen of What Country? 10e. Street and Numbe ō 21136 USA 23a 3850 Butler Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? filed within 72 hours after death Black, White, etc. 1 Yes 2 X No 1 Never Married 2 X Married "natural", or 1 Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) than Elementary/Secondary (0-12) Own Home Homemaker Page 1 and 2 should be filed wit. ment of Health and Mental Hygier ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Alice Frey ပ္ Ernest Luther Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3850 Butler Rd. Reisterstown, MD. 21136 Department of Health at Important: If item 27 is any injury or other trau Victor Frenkil, Jr./ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Timonium, MD. 7-20-12 Dulaney Valley Mem. 4 Donadon 5 Other (Specify) 22. Name and Address of Towson Funeral Home, Service Lice 21. Signatu of Fune 1050 York Rd. Towson, 23a. Part 1. Enter the lise lie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760[<] 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ 23b. Was decedent pregnant Year Month Day in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be director. examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes vithin 24 hours after co...

To the Funeral Director: After this contained in by the funeral director. ြို 28d. Describe how injury occurred 28a. Date of injury 28b. Time of 28c. Injury at 27. Manner of Death Certificate: (Month, Day, Year) iniury work 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

J State 29a. Certifier

(Check only or nature a

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

0

Registrar

Aniversi

gnature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Ny'se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 Julia A. Fanning 12:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 219-20-5115 Director 1 □ M 2**X**] F 86 Yrs 5/22/1926 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2816 Garnet Road 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 2 1 Never Married 2 Married 21215-0036 Specify White 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Deportment of Health end Mantel Hyglene. Important: If Item 27 is marked other than " any injury or other traumatic event, the Masones. Elementary/Secondary (0-12) College (1-4 or 5+) State Government Secretary Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. White Julia A. Galster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Fanning / Son 2816 Garnet Rd, Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Cemetery 7/19/2012 Parkville 21. Signature of Junetal Section License Parkview Funeral 7527 Harford Rd, Home & Cremation Parkville, MD 21234 23a. Part 1. Enter the lisease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should ba detached for usa as the burlel-transit Physician: The law requires that the deeth certificata ba executed Cause (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🗙 No |₽ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of Certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

a.m.

12:10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cei | tificate of L | Death | | 2. Date of Dea | Reg. No. | 201 | 3. Time of Death | |
| П | Physicia | | ROSE | | FEIT | | | | | 12 ^{Day} | 2012 | 11:53 PM | |
| A STATE OF | Medic Examin | | 4a. Facility Name (if not institution, give street an | | | 4b. City, Town, o | r Location | of Death | JULY | | County of Dea | | |
| - | | | GILCHRIST CENTER OF | | | COLUM | | | | | HOWAF | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 212-03-3155 1 □ M 2 | 7. Age (In yrs. I | | If Under 1 Year Months Days | Hours Hours | Min. | 8. Date of Birt (Month, Da | y, Year) | Co | rthplace (State or Foreign ountry) | |
| | | | Usual Residence of Decedent | 93 | Yrs. | | | | 03/05 | /1919 | 9 | MD | |
| | yland -f sho ed at | ctor | 10a. State 10b. County | 10c. Cit | y, Town or Lo | | | | | | | 10d. Inside City Limits 1 Yes 2 No | |
| | ne Ma or 28a notifi | Director | MD N/A 10e, Street and Number | | BALT | IMORE 10f. Zip Code | | | | 10a Citi | zen of What C | Λ | |
| | with the 23a cast be | Funeral | 6317 PARK HEIGHTS AV | ENUE, #62 | 1 | | 215 | | | rog. om | USA | out. | |
| | items items | | 11. Marital Status 12. Was | Decedent Ever in U.s ed Forces? | S. 13.1 | Was Decedent of H | Hispanic Origin? (Specify Yes or Neban, Mexican, Puerto Rican, etc.) | | cify Yes or No- Rican, etc.) | 14. Race - Am | | | |
| 36 | within 72 hours after death with the Maryland jiene. sr than "natural", or items 23a or 28a-f show than "natural", are most be notified at the Medical Examiner must be notified at | d by | 1 Never Married 2 Married 1 If Ye | Yes 2 XNo s, Give | 2 X No 1 ☐ Yes 2 | | | 2 XNo Specify: | | | | te, etc. VHITE | |
| 00- | hours natura ical E | lete | 15. Decedent's Education | or Dates. | 16a. Dece | dent's Usual Occup | ation | | | 16b. Kir | nd of Business | | |
| 21215-0036 | nin 72 ne. han " l e Med | Completed | | ege (1-4 or 5+) | life. D | kind of work done of NOT use retired) | | st of workir | ng | | | | |
| 121 | led within Hygiene. other than rent, the N | اما | 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First and First and Fi | | | | | | | Maidan | OWN HO | OME | |
| lanc | e d tal | To | HARRY | GARONZ | IK | | | ARAH | NETTIE | | urriarne) | RUBIN | |
| Maryland | 1 and 2 should be file f Health and Mental II item 27 is marked o other traumatic eve | | 19a. Informant's Name/Relationship (Type, Print) | | 1 | ng Address (Street | and Numl | ber or Rura | l Route Numbe | r, City or | Town, State, Z | ip Code) | |
| Σ, | | | SUSAN WEBER/DAUGHTEI | 1 | | WALDEN | MILL | WAY, | CATONS | | | 21228 | |
| Jore | | | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Remova | I from State | cemetery, crer | osition (Name of matory or other place | | | Date | | cation - City o | | |
| Baltimore, | | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure Funeral Service License | JROD | | EK CEMET: Name and Addre | | | 6/2012 L LEVIN | | ALTIMOR | | |
| Ba | permit. Departr Import any inji | | 182 | | | | | 001 | | | | MD 21208 | |
| | | | 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause | | h. Do not ente | er the mode of dyln | ig, such a | s cardiac o | r respiratory an | rest, | - | Approximate Interval Between | |
| , arting | Phy i i n Medical | | Immediate Cause (Final disease or condition resulting in death) | Severe Pa | rucyli | penia | | | | | | Onset and Death | |
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| _ | ate be executed hysician and the burial-transit | dical E | resulting in death) Last D | pe to (or as a conseq | uerice oi). | | | | | | | | |
| 3760 | ficate g phys as the | Medi | d | | | | | | | | | | |
| Box 687 | death certifica ne attending pl ed for use as t | an/N | | outcome of pregnancy ive Birth 2 Fetal death 3 Ectopic pregnancy | | | | | | | 3d. Date of delivery | | |
| | | Physician/Me | 1 Ves 2 No 4 - | Pregnant at time of Unknown | death 5 | Other (specify) _ | | | | Month Day Year | | | |
| Division of Vital Records, P.O. | that the | by Ph | Part II. Other significant conditions contributing | g to death but not res | sulting in the u | ınderlying cause gi | ven in Par | t I. | 23e. Did to | obacco us | se contribute t | o the cause of death? | |
| ds, | quires an sign | ed b | | | | .= | | | 1 🗆 | Yes 2 | □ No 3 □ F | Probably 4 X Unknown | |
| COL | law rec has bee ge 2 sho | Completed | | | | | | | 24a. Was autor | osy | prior to | utopsy findings available completion of cause of | |
| Re | : The lar cate ha r, page ? | | | | | | | | 1 🗆 Yes | rmed? 2 K No | death? | s 2 No | |
| ita | sician: The certificate irector, pag | Be c | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | 4 | ED/0 1 | Oth | er: | ath (Check | | | 77° 011 10 | city Hoebica | |
| of \ | g Physer this | te: To | 27. Manner of Death 28a. | 1 ☐ Inpatient 2 ☐ Date of injury (Month, Day, Year) | 28b. Time of injury | | y at | | me 5 🗌 Resid 28d. Describe h | | | ciry) Stospice | |
| lon | eath. or: After the funer | fical | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | (Worth, Day, Tear) | nijury | | Yes 2 | □ No | | | | | |
| ivis | or Att after d Direct I in by | Certificate: | 4 Homicide determined 286. | Place of Injury - At he building, etc. (Specify | | eet, factory, office | | 1 | 28f. Location (S City or Tow | | Number or Ru | ural Route Number, | |
| Ω | To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. | Medical | 29a. Certifier 1 Certifying Physician: To | | | | | | | | | | |
| | the Hohin 24 the Fu | Med | (Check 2 Medical Examiner: On to only one) 3 Certifying Nurse Practi | ne basis of examination in the best of the | n and/or inves my knowledge | , death occurred at | the time, d | occurred at late and pla | ce, and due to t | he cause(| s) and manner | as stated. | |
| | 5 V V V | | 29b. Signature and title of certifief | 2 MD | | 29c. Licens | e number 21 <i>3</i> 4 | 3 | | 29d. Date | signed (Mont | th, Day, Year) £ 20/2 | |
| | | | 30. Name and address of person who completed | | n 23a) (Tvpe. F | | | | | Jiu | 710 | 2012 | |
| _ | | | SYED Q. ABBAS 63 | d cause of death (Item 36 CED/ | AR LA | NE, CO | LUM | BIR | MD 2 | 2104 | 44 | | |
| | Sta Registra | | 31. Date filed (Month, Day, Year) | 3 . Registrar's Signa | ture | 111 | | | | | | | |
| | riogisti (| -21 | AAP T I PAIR | A Property land | 1 19 6 | | | | | | | | |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 10:21A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death de HAUre Grace Social Security Number 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 - F 212-28-3332 Months Min. Vear Hours Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits MD Aberdee HARFORD 1 Yes 2 No 9 10e. Street and Number ral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 2 1001 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Unite Year or Dates. NAU other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working -life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Be 17. Father's Name (First, Middle, Last) ဂ္ GApet 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of ➤ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory MEH. GAR. 7-19-2012 4 Donation 5 Other (Specify) HARFOND 21. Signature of Fineral Sovice Licenses Aberdeen 23a. Part 1. Enter the di or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart fa Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consection of and I-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician all the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 L 9 Unknown been signed by the a should be detached 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performed' this certificate Yes 2 -Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? 2 ONO Hospital ည 1 Yes 1 Inpatient 2 5 3/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending 24 hours after death. Funeral Director: At 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and of certified 29d. Date signed (Month, Day, Year) 19583 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 21001 ZATI

ORIGINAL

State

Registrar

DHMH 17 Rev 7/2009

1 7 2012

Please Type or Print in Black Indelible Jak., Ensure All Copies Are Legible. AMEND ITEM#5 perFH, 6929, 72012, W.S. All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** X: 33 P M REEN ARA 2012 lUL /Medical 4a. Facility Name (If not institution, give street and number) unty of Death 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country)

W • VA 8. Date of Birth (Month, Day, Year) 5 / 11 / 35 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 218-28-6543 Days 1 🗆 M 2 🔀 F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at N/A Baltimore 1¥ Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 21213 1401 N. Lakewood Ave-Apt. Funeral 14. Race - American Indian, Black, White, etc. African Specify: Amer 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) Admin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Cozette Eames Be Edward R. Lee ည 19a. Informant's Name/Relationship (Type. Print) Charlotte Scruggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Moravia Rd, Balt., MD 21206 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forrest Date 20c. Location - City or Town, State 7/23/12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitHari P. 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHari P. Close F.Svs,PA 5126 Belair Rd, Balt.,MD 21206-5105 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. RESPIRATOR Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** 1ASSIVE CEREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): PARADOXIC The law requires that the death certificate be executed as the burial-trar nding physician and Due to (or as a consequence of): IBRILLATION Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 - Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown een signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 X Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certifica e has 2 🗌 No 1 Tyes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ≥ No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 X Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA မ completely filled in by the funeral . Date of Injury (Month, Day Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident s after death 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral C To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 00

State Registrar

31. Date filed (Month, Day, Year)

FORSTER

32. Registrar's Signature

ares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHHEAN

4940 Eastern Avenue, Baltimore, MD, 21224

12-05236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 22487 Catherine Gleaton State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ July 11, 2012 1855 hrs Medical Examiner Catherine Gleaton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 318 Hance Avenue Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** 212-58-6809 Months Days Hours Director 03/13/1963 Country) Maryland 49 1 M 2 XF Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b, County 10c. City, Town or Location 1 Yes 2 X No 28a-f show maryland Anne Arundel Linthicum Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked ather than "natural", nr items 23a or 28a-f sho 10e. Street and Number items 23a or 28a-1 ust be notified at o 10f. Zip Code 10g. Citizen of What Country? 21090 318 Hance Avenue USA Funera 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year white 1 Yes 2X No specify: Specify: ò r Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked wither than "nijury or nther transmatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical 11 n/a n/a 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Frances Louise Corey Bill Gleaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Kuhling/sister 1920 Chipper Drive Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c, Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State |07/13/2012| Metro Crematory, Inc. Baltimore, Maryland Donation 5 Other Specify: Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval PartY. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Mixed drug (morphine, clomipramine, citalopram and ediate Cause (Final disease a mirtazapine) Intoxication Between Onset and /Medical Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to for as a consequence of Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Atteoding Physician: The law requires that the death certificate be executed attending physician and or use as the burial - tran Physician/Medical X UNPENDED \square AMENDED 23a,27,28a-f, per me,g929 7-24-12 smBox 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed by <u>8</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Anteuvure, within 24 hours after death.

To the Funeral Director: A 1 Naturai unknown 1 Yes 2 X No Division 5 Pending fd 7-11-12 fd 6:35 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 318 Hance Ave. Linthicum Heights, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) found at home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 12, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 31. Date filed (Month, Day, Yea 32. Registrar' Signatu State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:15A M 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ivy Hall Nursing Home Baltimore Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/17/1927 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ XF Maryland 218-22-5331 Director Usual Residence of Decedent 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Maryland Baltimore Rosedale 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1509 Rosewick Ave. 21237 United States death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the <u>once.</u> the Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman A. Ziese Beatrice L. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph W. Goddard. III 1509 Rosewick Ave. Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State 07/11/2012 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Serviso 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, MD 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac or near line. Immediate Cause (Final disease or condition nysician disease or condition resulting in death) /Medical ue to (of as a consequence of): Examine Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Box 68760. physician Physician/Medical the attending polyton for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate has , page 1∐ Yes CAY 2 **Division or Vital** as case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Uvrsing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 NO 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 No 2 Accident Funeral Director: stely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after (4 ☐ Homicide hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. the the within To the 29c. License number 29b. Signature and title of certifier 29d. Date sjgned (Mghth, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05279 Ronald W Goldstraw, Sr State of Maryland / Department of Health and Mental Hygiene 2012 22489 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 13, 2012 Medical Examiner 1623 hrs Ronald W. Goldstraw, Sr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Severna Park 161 Joanne Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign CountMaryland Days Hours July 7,1933 Director 79 212-30-4695 XX M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes XX No 28a-f show Maryland | Anne Arundel Severna Park with the Maryland Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21146 161 Joanne Road 14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status "natural", or items Examiner must be timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene.
That: If item 27 is marked other than "natural", or item; or other traumatic event, the Medical Examiner must ha If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 XMarried XX Yes If Yes, Give Year Specify: White 1 Yes XXXNo specify: 3 Widowed 4 Divorced ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PSI/ Transportation Truck Driver 12 +118. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Miller Be Charles Goldstraw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 161 Joanne Road, Severna Park, Maryland 21146 Charlsia Goldstraw / Wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 XXCremation 3 Removal from State July 17,20¶2 Glen Burnie,Maryland Atlantic Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Funeral Service License 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 5 MO 1456 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Immediate Cause (Final disease a Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of): Choking Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical AMENDED 23a-b, pt. II, 27, 28a-f, per me, g929 7-27-12 sm After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -X UNPENDED Box 68760, 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Live birth Fetal death Month Year 2 [past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>0</u> Š 1 Yes 2 No 3 ✔ Probably 4 Unknown laryngeal cancer, dysphagia Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural subject choked on paper towels 1 Yes 2 X No 5 Pending Director: d in by the f fd 4:10 pm fd 7-13-12 2 X Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) 161 Joanne Rd. verna Park, MD. within 24 hours at To the Funeral II completely filled determined (Specify) 4 Homicide Severna Residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

2. Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

July 14, 2012

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9 CRESTLINE COURT OWINGS MILLS BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8 Date of Rirth **Funeral** Days Hours Min. M 2 □ F Months 04/17/1920 Yrs 92 **Director** 213-14-8372 IL Usual Residence of Decedent 28a-f shov 10a. State Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD BALTIMORE OWINGS MILLS 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9 CRESTLINE COURT items 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced Specify. WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ ATTORNEY LEGAL n and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GORDON SAMUEL FANNY BARATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is I any injury or other **** CAROL JEAN GORDON/WIFE 9 CRESTLINE COURT, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK: 07/15/2012 4 Donation 5 Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility 21. Signature of Fineral Septic SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph.si i.n disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of cause of death? page perform 2 No Yes 1 🗌 Yes Be 25. Was case referred to medica Director: After this certifical in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, npleted filled 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) erson who completed cause of death (Item 23a) (Type, Print) VON

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MBERLU Ce Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Dundalk Baltimore 7291 Holabird Avenue 5. Social Security Number 217-92-6310 **Funeral** 6. Sex 7. Age (In yg. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. 1, (Month, Day, 9. Birthplace (State or Foreign Ju!Heth, 714, Year 1963 Maryland 1 □ M 2 F Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Dundalk Baltimore 1 Yes 2 No 10f. Zip Code 21222 10e. Street and Number 10g. Citizen of What Country? 7291 Holabird Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🕅 No 1 Never Married 2 Married BlackWhite 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Specify Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Water Cress retired) Matthews Pizza Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Myers ပ္ Ralph Clayton 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 04 Mill Creek Road Fallston, MD. 21047 at of He. Tr other tr Geraldine Kouba/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore, MD 07/16/12 1 ☐ Burial 2 ☐ XCremation 3 ☐ Removal from State
4 ☐ Denation 5 ☐ Other (Specify) BayviewCrematory or other place) permit. Page Department o Important: If any Injury or Balto. Muc 21221 21. Sig a ture 22. Name and Address of Facility 300 Connelly Funeral Mace Ave. Home of E of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Completed 1 Yes 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No e Hospital or Attending Physician: 7 124 hours after death. e Funeral Director: After this certifics Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Vithin 2 only one) 29b. Signature and titly of certifier 29c. License number pe and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Medical Holmes Year 2017 0004 Varise 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOP Kins NIA The Johns HOSPita Himore Age (In yrs. last birthday) Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign **Funeral** Hours Director 1 M 2 XF MD 197C DI 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore MD Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 23a or 10g. Citizen of What Country? by Funeral USA 6656 Collinsdate Road, Apt. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ustomer Service Representative Lifbam Industries 12th grade 1 year Be other traumatic event. 17. Father's Name (First, Middle, Last) and Mental h ဂ္ Raymond Holmes, Sr. Geathers vivia 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pumping Station Road 210 Kaymond Holmes, Jr. Hanover P.A 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Woodlawn Cemeter Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, each as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Abdominal use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last the attending physiciar Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director; After th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the I within 2 29b. Signature and ti RES-000 pleted cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore MD, 21287 31. Date filed (Month, Day, Year) State Registrar

Hoyle, Clifford

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| and show | 1 | ō | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | March | L / 9 | 1930 1 | _ | yland Od. Inside City Limits |
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| eath w | | Funeral | 11. Marital Status | 12. Was Decedent E | Ever in U.S | S. 13. \ | 21222 Was Decedent of His | spanic Origin | n? (Spec | ify Yes or No- | | 14. Race - A | | |
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| /lan d be fil Mental arked | | 은 | Burley Hoyle | | | | | | lphi | | Becl | | | |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any initiv or other traumatic event the Medical Examinar must he notified at | | | 19a. Informant's Name/Relationship (Mrs. Alice Ruth | | (a) | I | ng Address (Street a | | | | | | ٠. | |
| and 2 Health tem 2; | | ŀ | 20a. Method of Disposition | moyie (Wii | | | St. Clai | lre La | | Dundal ate | | Maryla: ocation - City | | 21222 |
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| Salti ermit. I epartri mporta | nce. | ı | 21. Signatur Juneral Service Licer | seeGregory 1 | Re | 1 22 | . Name and Address | s of Facility | | | | | | |
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| . → Physicia | un/ | | shock, or heart failure. List only Immediate Cause (Final | one cause on each line |). • | | | , suom as car | () | | | No company | | Approximate Interval Between Onset and Death |
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| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staffer death. The law reduction of the properties of the properties of the function and pricector. After this certificate has been signed by led in by the funeral director, page 2 should be detained. | i | by Ph | Part II. Other significant conditions | contributing to death b | ut not resi | ulting in the u | nderlying cause give | en in Part I. | | 23e. Did te | obacco | use contribute | e to the | cause of death? |
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| law recard has be e 2 sho | - | Completed | | | | | | | | 24a. Was autor | osy | prior | to com | sy findings available apletion of cause of |
| IRE In: The ficate or, pag | | | 25. Was case referred to medical | | | | 00.01 | (5 11) | /OI 1 | 1 🗆 Yes | 2 N | death | | 2 🗆 No |
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| n of ling Pr I. After th funeral | | | 27. Manper of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of injui (Month, Day | | 28b. Time of injury | 28c, Injury work? | at | 28 | 3d. Describe h | | | | |
| Sior Attend r death ctor: / | | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not 1 4 Homicide determined | De 280 Place of Injur | ry - At hor | me, farm, stre | | ∕es 2□No | | 8f. Location (S | Street ar | nd Number or | Rural F | Route Number, |
| Divi | 1 | | 4 - Homicide determined | building, etc | (Specify) | | | | | City or Tou | | | 7-7-7-01 | |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bid | : | Medical | (Check 2 Medical Exan | ysician: To the best of niner: On the basis of expension of the basis of expension or the basis of the basis | kamination | and/or invest | igation, in my opinior | n, death occur | irred at the | ne time, date a | and place | e, and due to the | ne caus | se(s) and manner stated. |
| To the within To the compl | | | only one) 3 ☐ Certifying Num 29b. Signature and title of pertifier | se Practitioner: To the | e best of m | iy knowleage, | 29c. License | number | | T | | e(s) and manne ite signed (Mo | | |
| | | | > temi | x sind | - h | | D2 | -876 | 2 | - | Ju | 14 15 | 5, ' | 2012 |
| 5 | | 1 | 30. Name and address of person who | | _ | | rint) | | | | 6.00 | ME | | 21237 |
| | State | | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signati | ure | - garic 1 | ~ 1 1 V C | U L | VIJIM | Ure | - , VV L | | 1621 |
| Regi | - | | JUL 1 7 20 | 2 Breus | B. | A Rus | 4 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Physician/ Month 7 Jacqueline Ann Hiebler 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedele If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 220-20-4307 85 1 🗆 M 2 🗓 F 6/17/1927 iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director MD Baltimore 3 Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 Windlass Drive 21220 United States Jacou elin 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) is marked other than "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ★ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A <u>Homemaker</u> 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Coleman Smith Carrie Fraumholz Hichler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hiebler 65 Northship Rd. Dundalk MD 21222 (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Denetion 5 X Other (Specify) Entombrent Holly Hill 7/14/12 neral Service Ligans e Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events sician and e burial-tran Due to (or as a consequence of) Records, P.O. Box 687606 resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown ed by the a a Haknowa signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fibrillation congestive Heart Failure 24a. Was an has page performed Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? s after death, Il Director; After t Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours at To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Pwithin 24 29b. Signature and title of certifier D68507 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Own Home 20c. Location - City or Town, State <u>Middle River. MD</u> Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 7-12-2012 9000 FRANKLIN SQUEUR DR Balto md 21237

Year

Baltimore

14. Race - American Indian. Black, White, etc.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 X No

Maryland

White

2012

135 AM

State

DR Soon

31. Date filed (Month, Day, Year)

backs

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14, Physician/ 11:56 AM July James T. Hamilton 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5713 Keithley Rd. White Marsh Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F May 01, 1922 90 Months Hours New York Director 091-12-9360 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medic 1 Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21162 5713 Keithley Rd. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No If Yes, Give Specify: Specify: 3 Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Steel Mill Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sherman Hamilton Ella Quinn permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Borchers /Daughter 34901 Preserver Lane Dagsboro, DE 19939 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 17 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician}/ -006 mass disease or condition resulting in death) VOOV Medical OBSTEUCTIVE Pulmmany Discuse **Examiner** Bequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform this certificate 1 ☐ Yes 2 1 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 27. Manner of Death 1 Matural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State, within 24 hours a To the Funeral C 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

completed

State Registrar 31. Date filed (Month, Day,

death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H41060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Benjamin Wei-Jen Huang Day 2012 Year July 12, 3:50 p M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 383-32-1309 XX M 2 □ F 85 7/29/1926 China Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Potomac 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10702 Gainsborough Road 20854 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Agricultural Economist Fed. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ding Hu Huang Kuo Chin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11208 Albermyrtle Road. Potomac, MD 20854 Abbott Huang, son 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 7/16/2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service of sie 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urosepsis Due to (or as a consequence of): Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Dementia Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Examiner HUANG BENJAMIN 7/11/18 @ 3.50 PM Division of Vital Records, P.O. Box 68760 To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f

Physician/

Medical

10a. State

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Examiner

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1 and 2 s of Health item 27

Physiciany Medical

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has e 2

Page 1 permit. Page 1
Department of I
Important: If it
any injury or of

within 72 hours after

Baltimore, Maryland 21215-0036

must be notified

Examiner

Medical

Exami Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Yes 2 🔀 N To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 1 € Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred XX Natural 5 Pending iniurv Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29c. License number 66 264

29d. Date signed (Month, Day, Year) 07/12/12

State Registrar 31. Date filed (Month, Day, Year, 7 2012

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babak Pirouz, MD; 8600 Old Georgetown Road Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 22:417M 74 Diane J. Hackney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown
If Under 1 Year | If Under 24 Hrs. <u>Baltimore</u> 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 278-42-8733 1 □ M 2 🗓 F 65 April 13,1947 Ohio en "neturel", or Items 23e or 28e-f show Medigal Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2x No Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? Funeral 410 Valley Meadow Circle, Apt T3 21136 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) £ 12 Nurse Medical permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Importent: If Item 27 is merked othe eny Injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Maymard Ralph Jackson Lillian Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Michelle Hackney 53 Pennsylvania Ave., Westminster, MD Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ACremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Carroll 7/16/2012 Cremation Hampstead. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Wayne Osterling Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart brillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin physician and s the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph d for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day n signed by the a uld be detached f Yes 2 /No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, or Attending Physicien: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Hospital: Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death of De Natural 28b. Time of نۆ 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Certificat Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Ivithin 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month William July 2012 5:46P M Charles Himes, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Months Hours (Month, Day, Year) Director 216-70-0089 1 12 M 2 □ F 51 Vre June 6, 1961 Maryland Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Carroll Union Bridge 1 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a Funeral 1 E. Elger St., Apt. 21791 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 farmer dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit, Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic Charles William Himes, Sr. Katherine Harbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vesta Himes/ wife E. Elger St. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 7/11/2012 AllCounty Cremation 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. 21. Signature of Figneral Service Licensee thorine Woodsboro, 404 S. Main St. 23a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician theroscient disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Physician: The law requires that the deeth certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 5 Other (specify) signed by the at d be detached f Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Ja. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe this certificate Yes 2 No 1 ☐ Yes 2 ☐ No ours efter death.

eral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 3/058 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene F. 10200 Coppermine Rd. Ashe Woodsboro, MD 21798 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 7 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 7 RAMMELI 23/2 6800 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel <u>Mandrin Inpatient Care Center</u> Harwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/7/1930 Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Hours Min. Director 242-36-1909 1 🗆 M 2 🖾 F 82 Georgia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant If item 27 is marked other than "natural", or items 23a or 28a-f shov lury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 U. S. A. 9 Fairway Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isaac Trammell (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 10 Saunders Point Lane Annapolis, Maryland 21403 Larry Hayes (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Holly Hill Mem. Gard, 7/16/2012 Middle River, Maryland ^{22, Name and Address of Facility} Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ UNG Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of Bertifier se of death (Item 23a) (Type, Print) npleted \mathcal{G}_{\prime} AVVID M a 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Tyrone Harris | | State of Maryland / Department of Health a 1-For State Registrar Certificate of Death | nd Mental Hyg | | 2 O | 12 225 |
|--|----------------|---|---|---------------------------------|--|--|
| hysician/ Med Exam | | Decedent's Name (First, Middle,Last) | | Date of Death Month | Day Year | 3. Time of Death |
| * | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, | or Location of Death | July 8, 2012 | 4c. County of Death | |
| Funeral | | Johns Hopkins Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Yo | ear If Under 24Hrs. | 8. Date of Birth | (MM/DD/YYYY) 9. Bir | thplace (State or Foreign |
| Director | | 220-52-7798 10 M 20 F 6 Yrs. Months D | ays Hours Min. | June | | untry) MP |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | ······································ | 10d. Inside City Limits |
| Maryland 28a-1 show any d at once. | tor | MD N/A Baltime | re | Lan | | 1 Yes 2 No |
| s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mertal Brigeren trum 21's marked other than "natural", or items 23a or 23a-f sho traumatic event, the Wester Investments be notified at once | Director | | 1205 | 109 | Citizen of What Cour | 54 |
| eath with items 2 ust be n | Funeral | 11. Manital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of F 14. Yes 2 No | dispanic Origin? (Speci pan, Mexican, Puerto Ric | | 14. Race - Ameri White, etc. | can Indian, Black, |
| s after de ral", or | by Fu | or Dates | | | Specify: BI | ack |
| S 72 hours afte n "natural", | pe | 15. Decedent's Education (Specify only highest grade completed) 15a. Decedent's usual occupal during most of working it | | done 1 | 6b, Kind of Business/1 | ndustry |
| 5-0036 iled within 7; Hygiene I other than | Complet | 12 FoStal | SOVEY 18.Mother's Name (Fin | ret Middle Mai | US tosta | 1 Service |
| 21215-0036 ruld be filed within 7 Mental Hygiene marked other than | Be | | June | Ha | rris | |
| and 2 should fealth and M tern 27 is m traumatic e | To | 19a. Informant's Name/Relationship (Type, Print) 19b. Marling Address (St. June John Son 1441 Wat | reet and Number or Run | 5 11 | er, City or Town, State, | Zip Code) |
| Baltimore, MD 21215-003 permt. Pages I and 2 should be filed with Department of Evalua hand Abratal Hygiene Important: It lieral 271s marked other injury or other traumatic event, the National Pages. | | 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of corrematory or other place) | emetery, D | | 20c. Location - City or | Town, State |
| Baltimore, permit. Pages 1 ar Department of Hes Important: If the injury or other tr | | 4 Donation 5 Other Specify 21. Size lure of Funerel Scripts 122. Name and Address | st 7/2 | 0/2012 | DWINGS | Mils, MD |
| | - | Dun X. Howell St. 4600 L | iberty H | rights | Aw. Bo | ito MD |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications thel caused the death. Do not enter the mode of dying, failure. List only one cause on each line. Immediate Ceuse (Final disease a Hypertensive Atherosclerotic Cardiovascular D | | oiratopy arrest, | shock, or heart | Approximate Interval Between Onset and Deeth |
| Examiner | | or condition resulting in death) Due to (or as a consequence of): | isease | | | |
| | ner | Sequentially list conditions, If any, keeding to himselfatt Cause, Enter Underlying Cause | | | | |
| Sit Sd | Examiner | (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence o.). | | | | |
| 760, cate be executed physician and he burial - transit | Medical E | UNPENDED AMENDED | | | | |
| 3760, ficate bo g physic s the bur | | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 | Ectopic pregnancy | | 23d. Date of delivery | ay Year |
| Records, P.O. Box 68760, The law requires that the death cartificate be executed take has been signed by the attending physician and page 2 should be detached for use as the burial - trans | slcian/ | past 12 months? 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | | | MOINT C | ay Year |
| P.O. B es that the de igned by the | y Physi | Part II. Other significant conditions contributing to death but not resulting in the underlying cause of | given in Part I. | 23e. Did toba | cco use contribute to the | ne cause of death? |
| rds, P requires the been signe | ted by | chronic alcoholism | - | 1 Yes 24a. Was an | 2 No 3 Prob | ably 4 X Unknown opsy findings aveilable |
| Division of Vital Records, rador Attending Physician: The law requirated and the this certificate has been sided in by the funcral director, page 2 should be in by the funcral director, page 2 should be a second to the funcral director, page 2 should be a second to the funcral director, page 2 should be a second to the funcral director, page 2 should be a second to the funcral director. | Completed | | | eutopsy perform 1 X Yes 2 | prior to d | ompletion of cause of |
| tal Recision: The certificate ector, page | Be Cc | eyaminer? | ce of Death (Check only | one) | | 2 1 10 |
| of Vige Physical Charters of the Christon of t | 욘 | 1 X Yes 2 No I I I I I I I I I I I I I I I I I I | Other Nursing He | | esidence 6 Other: vinjury occurred | |
| Sion (trendin death. | atlon | 2 Accident Investigation | Yes 2 No | | | |
| Divis | Certification: | 3 Suicide 6 Could not be determined (Specify) | building, etc. 286 | Location (Stre or Town, Stat | eet and Number or Run e) | al Roule Number, City |
| Division of Vital F To the Hosp and or Attending Physicism: within 24 hours after death. To the Pameral Director: After this certifi completely filled in by the funeral director, | - 1 | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion | | | | 31156(5) |
| Tot with Tot | Medical | and manner stated. | nse number | | 9d. Date signed (Mon | |
| | | Theodore the mit of the se. D. | M.E. OCM | | July 9, 2012 | |
| <i>B</i> √ | | 30. Name and address of person who completed cads of death (Item 23e) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltim | nore Street, Baltime | ore, MD 212 | 223 | |
| Si Regis | ate rar | 31. Date filed Wasth, Pay Year 1012 Senema S. Sank | | | | |
| DHMH 17 Pay 1/20 | | ORIGINAL | | | · · · · · · · · · · · · · · · · · · · | |

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